San Diego County Report Card on Children and Families

REPORT CARD 2007

San Diego County Report Card on Children and Families 2007

Produced in partnership with the County of San Diego Board of Supervisors

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This Report Card available in electronic format at
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The Children's Initiative

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The 2007 *San Diego County Report Card on Children and Families* is the continuation of a series of annual reports that provide a summary of the overall health and well-being of our county's children, youth, and families. These reports have been produced annually since 1999 by the County of San Diego Health and Human Services Agency. Starting this year, the *Report Card* will be produced biennially by The Children's Initiative, a nonprofit child advocacy agency in San Diego. Building upon previous report cards and reflecting best practice from around the country, The Children's Initiative has introduced changes in content and formatting.

This *Report Card* has been produced through a public/private partnership that includes the County Board of Supervisors, Health and Human Services Agency, The California Endowment, the Charles Stewart Mott Foundation, the McCarthy Family Foundation, and the Parker Foundation. The study and selection of health indicators has been guided by a Leadership Advisory Oversight Committee, comprised of local and national experts in the fields of health, education, child care, child welfare, juvenile justice, and injury and violence prevention. The data research and analysis has been overseen by a Scientific Advisory Review Committee, consisting of data analysts, statisticians, epidemiologists, and data managers from these same fields of study.

For this *Report Card*, 25 indicators were selected to measure the health and well-being of children and families. A nationwide scan of report cards was conducted to investigate what indicators and what data sources are used by other communities. From this scan and the prior *Report Card*, an expanded list of potential indicators was developed. The Children's Initiative applied nationally recognized criteria used in results-based accountability projects in order to select indicators. In plain words, we examined each indicator and asked: Do we have reliable and consistent data? Does the indicator communicate to diverse audiences (e.g., families, communities, policy makers)? And does the indicator say something of importance about the desired outcome? Using this decision model, we retained some previous indicators, put some aside for data development, and are introducing new ones.

Indicators that are newly reported in this *San Diego County Report Card* are: prenatal care, breastfeeding initiation, obesity, juvenile arrests, youth driving under the influence of drugs or alcohol, and childhood mortality.

Other indicators were modified. The juvenile probation measure now reflects the number of sustained petitions (true finds), rather than all petitions filed, to make the indicator more closely reflect how many juveniles will be formally placed on probation. The indicator for oral health now is the percent of children who have never seen a dentist, again, closer to the issue of concern. The most significant modification has been for school attendance. Previously, county *Report Cards* reported on Average Daily Attendance (ADA); however, this number does not tell if students are missing school days to a degree that may negatively affect their educational success. To gather data on this cohort of at-risk students, The Children's Initiative established agreements with each school district in order to obtain the information, and we are pleased to present this indicator for the first time.

In addition to reporting the current status of the indicators and the trends in the last few years, the *Report Card* for 2007 introduces two new types of information: national best practices for prevention and intervention, and recommendations for action specific to San Diego County. This information was added to enhance the *Report Card's* capability as a tool for policy development, targeted prevention and intervention, community education, and future research.

Summary of Trends

Positive trends and comparisons are shown for three out of the four indicators for infants and toddlers. One trend, low birth weight, is of concern.

- **The percent of mothers receiving prenatal care.** The trend is increasing, although we are shy of the national objective.
- **Low birthweight birth.** The trend is moving in the wrong direction. In San Diego, as elsewhere in the nation, the proportion of babies born at low and very low birth weight is increasing.
- **Breastfeeding initiation.** The trend is improving gradually. San Diego County rates are better than the state average and exceed the national objective.
- **Births to teens.** The trend was improving, but progress has leveled off in the last three years. Our rate is better than the state and national averages.

For preschool age children, we are doing well on both indicators. The challenge for this age group is to collect more data and better measure their progress toward healthy development and school readiness.

- **Immunization.** The trend is gradually improving in San Diego County, but there is still work to be done. San Diego is currently slightly above the state average, but still below the national objective.
- **Early child care and education.** Two years of data are represented. The San Diego rate is above the state and national averages.

Among school age children, there is some progress; yet of concern, too many are overweight and/or missing too many days of school.

- **Oral health.** While the trend is improving, more than one in eight of our preschool and school age children have never had a dental visit.
- **School attendance.** Since this is the first year of collecting this data, no trend can be determined. Currently 27% of students in grades K-5 attended school less than 95% of the time in school year 2006-07.
- **School achievement.** The trend for achievement in English Language Arts for third graders improved slightly, but not in a substantial way (from 39% to 42%). Our county is slightly above the state average.
- **Obesity.** The trend is maintaining. With 30% of fifth and seventh graders testing overweight, we are falling far short of the national objective of 5%.

Our adolescents are doing better than ever in some areas. Yet many of our youth remain at risk for school failure, car crashes, delinquency, substance abuse, depression, and suicide.

- **School attendance.** Since this is the first year of collecting this data, no trend can be determined. Currently 24% of students in grades 6 to 12 attended school less than 90% of their school days in school year 2006-07.
- **School achievement.** The trend for achievement in English Language Arts scores among eighth and eleventh graders is improving and remains slightly above state averages. Of concern is that achievement rates drop off between eighth and eleventh grade.
- **Substance abuse.** The trend in use of alcohol, cigarettes, and marijuana continues to decline, with San Diego County students reporting lower levels of use than the national average and comparable to state rates.
- **Youth suicide.** No trend data was available. About 11% of students reported having made one or more suicide attempts within the past 12 months. The data indicate that middle school students are at greatest risk.
- **Juvenile crime.** The overall trend is improving over time, although arrest rates did increase slightly in 2006; the first increase in eight years. Misdemeanor arrest rates continued to decline.
- **Juvenile probation.** The trend is increasing. The number of sustained juvenile court petitions has been steadily increasing over time, even though overall arrest rates are declining.

- **Youth DUI arrests.** The trend is maintaining. The number of arrests of 16-20 year olds remains steady.
- **Motor vehicle crashes involving youth DUI.** The trend is maintaining. The rate of alcohol- and drug-related crashes among drivers ages 16-20 has remained at essentially the same level and worse than the state average for that age group.

Our community and family indicators are generally improving. Of concern, is lack of substantial progress in reducing poverty and mortality. These two broad indicators may point to underlying problems in the health and safety net of our community.

- **Poverty.** The trend is maintaining. While the percent San Diego County children living in poverty is lower than the state and the nation averages, we are not making substantial progress in reducing the proportion of our children who live in poverty.
- **Health coverage.** The trend is improving. By 2005, 93% of San Diego's families reported that their children had health coverage. San Diego County was on par with the state average, and well above the national rate.
- **Domestic violence.** The trend is improving. The rate of domestic violence reports is declining in San Diego County, although it remains above the state average.
- **Child abuse and neglect.** The trend is improving The rate of substantiated reports has been slowly declining in recent years, but remains higher than the state average.
- **Violent crime victimization of children.** The trend is maintaining. Of concern is that after declining steadily from 1999-2003, the rate of victimization for youth ages 12-17 has returned to the highest rate since 1999.
- **Unintentional injury and death.** The trend is improving. The rate of non-fatal unintentional injuries to children has been decreasing and San Diego County's childhood injury rates have been slightly below the state average.
- **Child mortality.** The trend is maintaining. The rates of mortality for children ages 1-4 decreased slightly from 2000-02 and increased slightly 2002-04. This pattern was reversed for children ages 5-14.

Recommendations for Action

Based on what works and what San Diego County has done so far, the top ten recommendations for local action are presented here. These recommendations were developed in collaboration with local leaders from the public and private sectors.

Overall, our top recommendations for action in San Diego County include:

1. **Low Birthweight:** Develop a interconception (between births) care initiative to provide augmented services for 24 months to the highest-risk, lowest-income women who have had a prior low birthweight birth, miscarriage, or infant death.

2. **Oral Health:** Expand capacity in the "dental care safety net," including placement of dentists in community clinics, mobile dental services, and prevention services in early care and education settings, elementary schools and after school programs.

3. **School Attendance:** Start supportive interventions at the fifth absence including connecting with parents, assessing the child's issues and concerns and providing immediate individualized intervention services.

4. **School Achievement:** Develop a standardized, county-wide kindergarten entrance assessment of school readiness, including a plan for immediate intervention when children lack basic pre-reading skills.

5. **Obesity:** Expand healthy nutrition classes and education at community clinics, WIC centers, early care and education settings, and community centers.

6. **Juvenile Probation:** Expand Juvenile Diversion services with law enforcement throughout San Diego County and with high school and middle school suspension and expulsion boards.

7. **Driving Under the Influence (DUI):** Provide education to parents about the dangers of "social host" parties for youth and enact a liability law that imposes civil penalties and harsh fines on adults who provide alcohol to youth.

8. **Poverty:** Expand services such as financial planning, education, job placement, and skill training to poor and low-income families.

9. **Child Abuse and Neglect:** Expand participation in parent support groups and parenting classes through incentives such as child care, store certificates, and meal provision.

10. **Childhood Mortality:** Implement the recommendations of the Child Death Review Team and take action to further prevent deaths.

INTRODUCTION

Report cards are valuable tools used to measure and monitor the well-being of populations. This *Report Card* monitors how well San Diego County's children and youth are doing in terms of health, education, safety, and economic security. Report cards are designed to raise community awareness and educate the public about current issues and trends relating to the health and well-being of children and youth. These reports can point to positive results, troublesome trends, and make recommendations for change or continued support in policies and programs.

Results (or outcomes) are conditions of well-being for children, adults, families, or communities. They are what we hope to achieve as a community: including children who are healthy, ready for and succeeding in school, avoiding risky behaviors, and staying out of harm's way. We aim for families to have economic security and safe homes and neighborhoods. Report cards focus on results, as the means to further reduce risks, improve outcomes, and contribute to greater equity for our children and youth, under the principle of "what gets measured, gets done."

Report cards include indicators that serve as benchmark measures to monitor our progress toward the desired results. They tell us how we are doing. For this *Report Card*, 25 indicators were selected to measure the health and well-being of infants and toddlers, preschoolers, school age children, and adolescents, as well as status across ages such as poverty rates. These indicators do not tell us the whole story; they do serve as leading indicators to let us know if trends are improving or not, and if kids are doing well.

While sound policies and the efficient allocation of resources are important, other factors influence our children's outcomes. Our public and private programs work to improve the health and well-being of the people they serve, but getting good results often depends on effective implementation of integrated strategies across systems and agencies. While there are no single shot or silver bullet strategies, research tells us much about what strategies have proven effective to improving the conditions of children and families. For each indicator, we have included a list of what works based on evidence from across the United States. Finally, this *Report Card* offers San Diego-specific recommendations, based on what works, in order to improve results for children and their families.

San Diego Report Card History

Beginning in 1998, the San Diego County Health and Human Services Agency (HHSA) undertook the development and publication of the *Report Card on San Diego County Child and Family Health and Well-Being*. For seven years, this report on trends was funded primarily by and published by HHSA. The last edition of that *Report Card* was issued for year 2005. As County services were reconfigured, the Board of Supervisors searched for an alternative way to produce and publish this important document. The Board of Supervisors partnered with The Children's Initiative, a local non-profit agency, which serves as an advocate and custodian for effective policies, programs, and services that support the health and well-being of children, youth, and families, to study the characteristics of effective and sustainable report cards in other jurisdictions. The Board of Supervisors and The Children's Initiative have worked together for many years in the development and implementation of policies, programs and services to support children and youth.

The Children's Initiative commissioned the San Diego State University (SDSU) School of Business to conduct a study to identify best practices in developing and sustaining community report cards from across the country.

The study found that:

1. Report cards are part of a process for raising community awareness and working with initiatives and programs that move toward creating child and family policies and advocacy strategies, not just an exercise in selecting and reporting indicators.
2. Public and community engagement are critical to the success and sustainability of these efforts. This begins with the inclusion of a broad and diverse array of stakeholders in selection of indicators and assumes responsibility for informing families, communities, and policy makers about the findings.
3. Across the country, state and local report cards that have relied only on one funding stream or strictly on government funding have been unable to secure consistent financial support.
4. It is essential to link what is learned to a process for program and policy change, where community members and policy makers mobilize together to implement strategies to increase public investment for children, youth, and families. This means using the *Report Card* as one tool in a results-based accountability effort that engages all of these stakeholders.

Given this larger perspective on the role and strategy for report cards, in January 2006, the San Diego County Board of Supervisors approved the transfer of ownership and responsibility for the county *Report Card* to The Children's Initiative.

2007 Report Card Development Process

The Children's Initiative, building upon previous report cards, has introduced significant changes reflecting best practice from around the country. The Children's Initiative involved a broad array of stakeholders, updated and added new indicators, reported on effective practices, and provided recommendations. Public and private funders came together to support this revised approach, including the Charles Stewart Mott Foundation, The California Endowment, San Diego County Health and Human Services Agency, the McCarthy Family Foundation, and the Parker Foundation.

This *Report Card* was developed as a public-private partnership with stakeholders from all levels of communities. It reflects the advice and expertise of: public agency and government officials; subject matter experts in education, health, and other fields; providers and community-based organizations; and parents and youth. Both a Leadership Advisory Oversight Committee and Scientific Advisory Review Committee were convened to guide the entire process. Project staff met with schools, physicians, law enforcement, family advocates, and others. The Children's Initiative received input and guidance from a broad array of subject matter experts and community representatives during the process of selecting indicators, identifying and securing reliable data, identification of best practices, and developing specific San Diego recommendations.

Local and national experts were involved in selecting indicators to assure that the indicators used in this *Report Card* are both valid measures and meaningful to the community. A nationwide scan of report cards was conducted to investigate what indicators and what data sources are used by other communities. From this scan and the prior *Report Card*, an expanded list of potential indicators was developed. The Children's Initiative used widely recognized principles and criteria in the indicator selection process. The staff and advisory committees examined each indicator to determine which indicators had the strongest data, the best communication power, and reflected most broadly on a given topic such as crime or mortality. In plain words, the committees examined each indicator and asked: Do we have reliable and consistent data? Does the indicator communicate to diverse audiences (e.g., families, communities, policy makers)? And does the indicator say something of importance about the desired outcome?

With the advice of community stakeholders and subject matter experts, the indicator groupings were modified. Rather than grouping indicators according to a category of need (e.g., Safety, Access to Services), this *Report Card* groups indicators according to stages of childhood. This provides a logical and easy-to-follow progression for the reader. Indicators are assigned to the age group in which they occur: Birth to three years

(infants and toddlers), three to six years (preschool), six to twelve years (school age), and thirteen to eighteen years (adolescence). Lastly, there is a group of indicators that affect all ages (community and family).

In addition to reporting the current status of the indicators and the trends in the last few years, this report goes still further to establish itself as an agent for change. The *Report Card* for 2007 introduces two new types of information: national best practices for prevention and intervention, and recommendations for action specific to San Diego County. Best practices were identified from nationally respected sources such as universities, government agencies, and other research organizations, and meet the standards of research based outcomes. Recommendations for action in this *Report Card* were designed by the Report Card Committee members, subject matter experts, and national consultants. Due to the "snapshot" nature and space constraints of the *Report Card*, these sections offer examples and are not intended to be exhaustive or complete lists of possibilities.

Understanding This Report Card

To use this *Report Card* most effectively, it is helpful to understand how the data are presented. The most recent data available at the time of production are generally used. Depending on the type and source of information, the most recent data available may be for 2004, 2005, 2006, or 2007. As discussed above, some indicators from past *Report Cards* have been eliminated or modified, and some new indicators have been added. For retained indicators, every effort was made to use the historical data source when possible, for reasons of continuity. To present more reliable or most recent information, we sometimes secured new sources of data.

Trend charts were used to illustrate the status of an indicator over time. No tests have been done to determine the statistical significance of time-trend changes; we are only observing whether the trends are improving, maintaining, or worsening. It is important to note that a change in a specific rate for one year may be the result of a temporary environmental change, a change in data sample, or some other extraneous influence, and may not represent a true change in the trend. When possible, state and/or national comparison data is presented to assist in understanding how our county is doing in comparison to the California or United States averages, as well as to national objectives set by the U.S. Department of Health and Human Services.

Data are presented in percentages and rates, reflecting the data norms and standards. Using these standardized measures makes it easier and more accurate to look at trends or make comparisons. A percentage is the most easily understood comparison and is used whenever appropriate. Rates per 1,000, 10,000, or 100,000 people are used when the incidence of a condition is low.

Most charts are shown for calendar years. Three-year averages are used when the population referred to is small, or when the data are likely to have year-to-year fluctuations that do not indicate actual underlying change in the indicator. For education data, the trends are shown in school years (e.g., 2004-05).

Most charts show data on a scale of 1 to 100, 1 to 50, or 1 to 25, depending on the level of the trend. For some, however, the scale has been modified to better show the variation year-to-year. When that occurs, the chart is marked with the words "note scale."

In a few instances, numbers instead of percentages or rates are used. This is done when it would be impossible to calculate the denominator — the number of individuals who might be subject to a condition. So, for example, we report the number of youth DUI arrests.

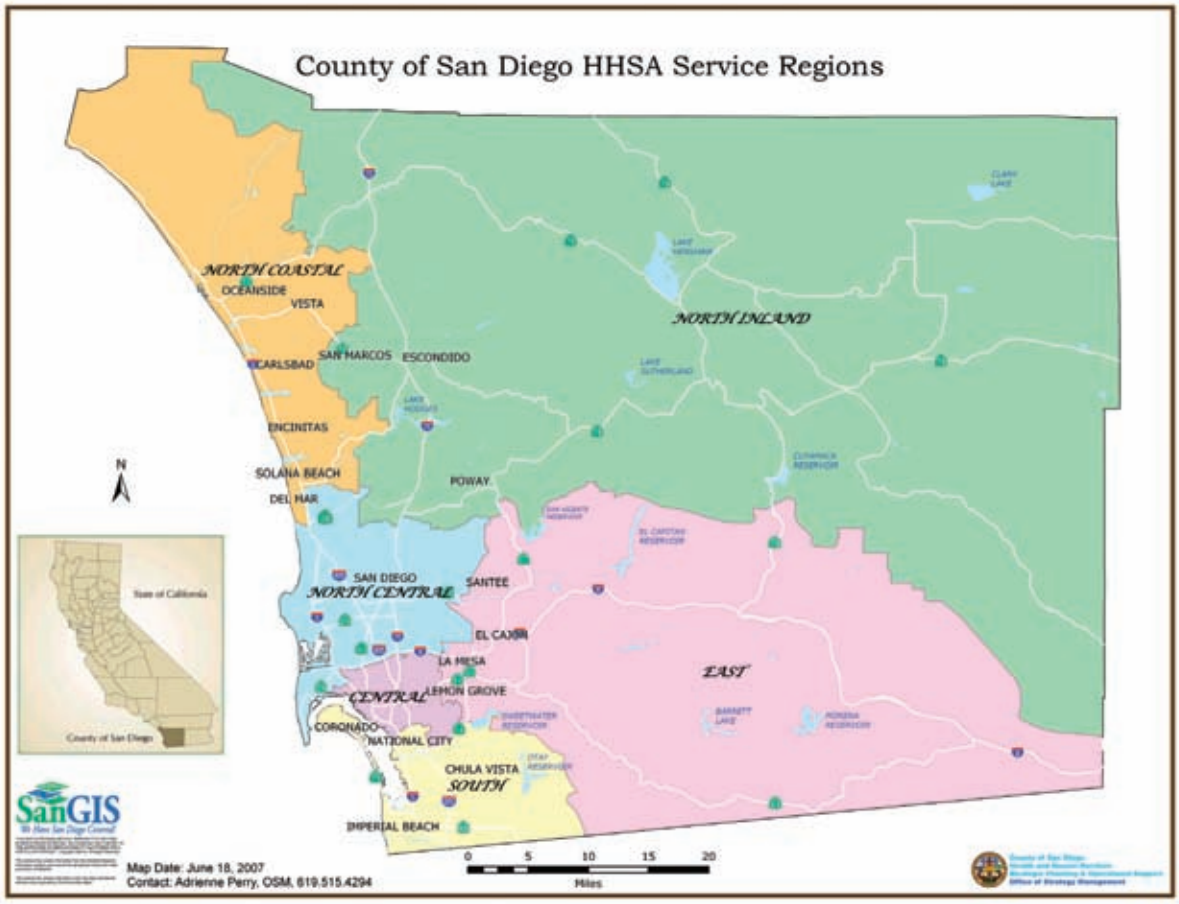
Notes on Geographic and Racial/Ethnic Data

San Diego is a large county, stretching 65 miles from north to south, and 86 miles from east to west, covering 4,261 square miles, just slightly smaller than the entire state of Connecticut. It borders Orange and Riverside Counties to the north, the agricultural communities of Imperial County to the east, the Pacific Ocean to the west, and the State of Baja California, Mexico, to the south. With an elevation that goes from sea level to 6,500 feet, our county includes beaches, valleys, deserts, and mountains. Our communities are diverse in population and occupation, incorporating urban, suburban, and rural neighborhoods. San Diego County is comprised of 18 incorporated cities and 17 unincorporated communities. The County of San Diego HHSA groups these cities and communities by zip code into six geographic regions: Central, North Central, South, North Coastal, North Inland, and East. HHSA prepared geocoded maps for this *Report Card* where data and space permitted their use.

The county's total population in 2007 is estimated at approximately 3 million (SANDAG Profile Warehouse), and it remains the third most populous county in the state. Children under age 18 represent 25% of our population, and those under 5 represent about 8% of San Diego County residents.

SANDAG reports that the region's population under 18 is distributed throughout urban, suburban, and rural areas, notably in inland communities. Areas with the highest concentrations — with more than one-third of the population being children under age 18 — are in Vista, San Marcos, Escondido, and in communities within the City of San Diego. These communities include Carmel Valley, Mira Mesa, Sherman Heights, Encanto, City Heights and San Ysidro. In the part of Tierrasanta that contains off-base Navy family housing, 54% of the population is under age 18. Most of the areas with the lower percentages of children tend to be found adjacent to the coastline or in neighborhoods near large universities.

This is an ethnically diverse community. The overall population consists of 52% non-Hispanic white, 29% Hispanic, 5% African-American, 10% Asian, Hawaiian, or Other Pacific Islander; and 0.5% Native American or Alaskan Native; and 3% who claim two or more races in their background (SANDAG Profile Warehouse). The population of children under age 18 is similarly distributed, with slightly more having Hispanic and Native American origins. San Diego County has 18 American Indian reservations, more than any other county in the United States, representing four tribal groups. Data on race and ethnicity are not uniformly available for the indicators we've used. We are limited by what is collected and reported in local, state, and national databases. (For example, some databases do not show data for Native Americans, others show a dozen categories of Asian residents but group all Hispanics together.) Where appropriate and meaningful, we have included tables showing racial/ethnic variations for specific indicators.


County of San Diego HHSA Service Regions
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VISTA
CARLSBAD
SAN MARCOS
ESCONDIDO
ENCINITAS
SOLANA BEACH
DEL MAR
POWAY
NORTH INLAND
SAN DIEGO
NORTH CENTRAL
SANTEE
EL CAJON
LA MESA
LEMON GROVE
CENTRAL
CORONADO
NATIONAL CITY
CHULA VISTA
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SanGIS
Map Date: June 18, 2007
Contact: Adrienne Perry, OSM, 619.515.4294
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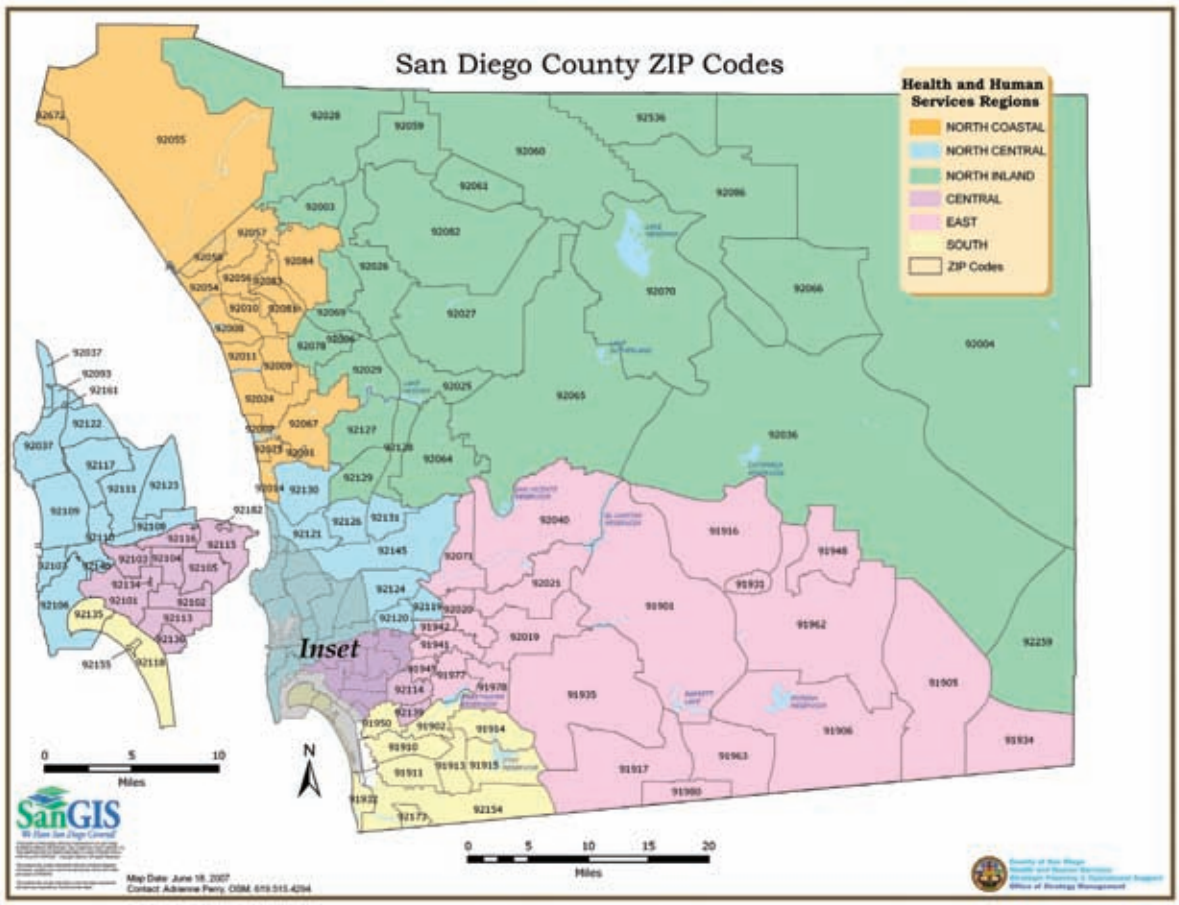
San Diego County ZIP Codes
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NORTH CENTRAL
NORTH INLAND
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San Diego County Report Card on Children and Families 2007
REPORT CARD SUMMARY TABLE[1]
COUNTY, STATE, and NATIONAL COMPARISONS

Birth to Age 3 (Infants and Toddlers)		**San Diego County**	**California**	**United States**	**Healthy People 2010 Goal**
The percent of mothers receiving early prenatal care		86.0	85.9	n/a	90.0
The percent of infants born at low birth weight		6.6	6.9	8.2 (2005)	5.0
The percent of women who initiate breastfeeding of newborn in hospital		90.0	86.5	n/a	75.0
The birth rate per 1,000 teens ages 15-17 years		18.5	20.3 (2005)	21.4 (2005)	n/a
Ages 3-6 (Preschool)					
The percent of young children (ages 19-36 months) who completed the basic immunizations series		82.8	80.3	80.6	90.0
The percent of children ages 3 and 4 enrolled in early care and education		52.8 (2005)	46.6 (2005)	45.2 (2005)	n/a
Ages 6-12 (School Age)					
The percent of children ages 2-11 who have never visited a dentist		13.6	15.0	n/a	n/a
The percent of elementary school (K-5) students who did not attend school at least 95 percent of school days		27	n/a	n/a	n/a
The percent of students in grade 3 scoring proficient or advanced on the English Language Arts achievement test		42	36	n/a	n/a
The percent of students not in the Healthy Fitness Zone	Grade 5	30.0	32.6	n/a	5
	Grade 7	31.2	33.0	n/a	5
	Grade 9	32.9	32.0	n/a	5

San Diego County Report Card on Children and Families 2007
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COUNTY, STATE, and NATIONAL COMPARISONS

Ages 13-18 (Adolescents)		San Diego County	California	United States	Healthy People 2010 Goal
The percent of middle and high school (grades 6-12) students who did not attend school at least 90 percent of school days		24	n/a	n/a	n/a
The percent of students scoring proficient or advanced in English Language Arts test	Grade 8	47	41	n/a	n/a
	Grade 11	38	36		
The percent of students who reported using cigarettes in the past 30 days	Grade 7	4	4	n/a	n/a
	Grade 9	6	9	24	n/a
	Grade 11	14	14	30	n/a
The percent of students who reported using alcohol in the past 30 days	Grade 7	11	13	n/a	n/a
	Grade 9	18	28	36	n/a
	Grade 11	37	37	46	n/a
The percent of students who reported using marijuana in the past 30 days	Grade 7	3	4	n/a	n/a
	Grade 9	7	12	17	n/a
	Grade 11	15	16	21	n/a
The percent of male students who reported they attempted suicide in the previous 12 months	Grade 7	12	n/a	n/a	n/a
	Grade 9	5	n/a	n/a	n/a
	Grade 11	4	n/a	n/a	n/a
The percent of female students who reported they attempted suicide in the previous 12 months	Grade 7	11	n/a	n/a	n/a
	Grade 9	6	n/a	n/a	n/a
	Grade 11	5	n/a	n/a	n/a
The number of arrests for misdemeanor and felony crimes among youth ages 10-17.		14,674	n/a	n/a	n/a
The number of sustained petitions (true finds) in Juvenile Court among youth age 10-17.		5,228	n/a	n/a	n/a
The number of DUI arrests among youth under age 18		139 (2005)	n/a	n/a	n/a
The rate of fatal and non-fatal crashes involving drivers ages 16-20 under the influence of alcohol or drugs per 100,000 population		105 (2005)	84 (2005)	n/a	n/a

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REPORT CARD SUMMARY TABLE[1]
COUNTY, STATE, and NATIONAL COMPARISONS

Community and Family (Cross Age)		San Diego County	California	United States	Healthy People 2010 Goal
The percent of children age 0-17 living in poverty		15.9 (2005)	18.6 (2005)	18.5 (2005)	n/a
The percent of children age 0-17 who are without health coverage		6.9 (2005)	6.4 (2005)	17.6 (2005)	n/a
The rate of domestic violence reports per 1,000 households		18.5	14.3	n/a	n/a
The rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17		12.8	11.1	n/a	n/a
The rate of violent crime victimization per 10,000 children or youth	Ages 0-11	6.1	n/a	n/a	n/a
	Ages 12-17	73.5			
The rate of unintentional injuries per 100,000 children ages 0-18		253.6 (2005)	n/a	n/a	n/a
The mortality rate per 1,000 children ages 0-17		5.4 (2004)	5.2 (2004)	6.8 (2004)	4.5 (2004)

[1] All numbers are for the year 2006 unless otherwise noted.

"When we talk about giving every child a healthy start in life…we mean safe pregnancies, which begin even before conception with Folic Acid intake and other forms of good nutrition...and early prenatal care." *David E. Satcher, former U.S. Surgeon General*

Birth to Age 3 (Infants and Toddlers): EARLY PRENATAL CARE

What is the indicator?

The percent of mothers receiving early prenatal care.

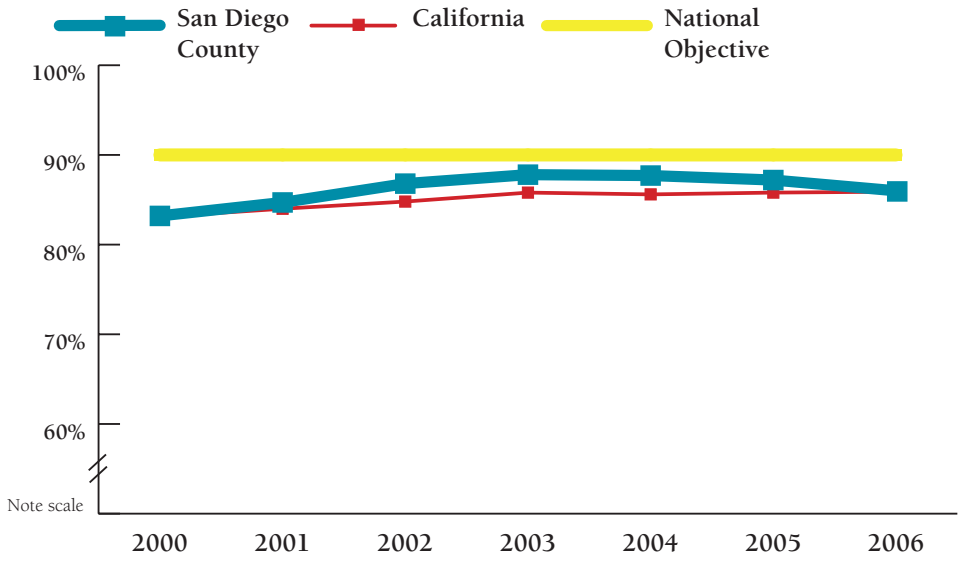
This indicator — the percent of mothers receiving early prenatal care — reflects the percent of women who receive prenatal care beginning in the first three months (referred to as the first trimester) of pregnancy. A related measure is "adequate" prenatal care, which accounts for both the timing of entry into care (early, late, etc.) and the number of visits. Prenatal care information is recorded on the birth certificate and reported as part of local, state, and federal vital statistics.

Why is this important?

Prenatal care from a qualified health professional is recommended to monitor the health of a woman and her baby during pregnancy. Optimal care includes medical services and health promotion and education. According to the Centers for Disease Control and Prevention, early and adequate prenatal care is associated with healthier birth weight and a lower risk of a premature baby. Beginning care early, during the first three months of pregnancy, gives time to monitor and intervene if a problem is detected. Inadequate prenatal care (starting late or too few visits) has been associated with premature birth, low birth weight, and increased risk of mortality for the fetus, infant, and mother.

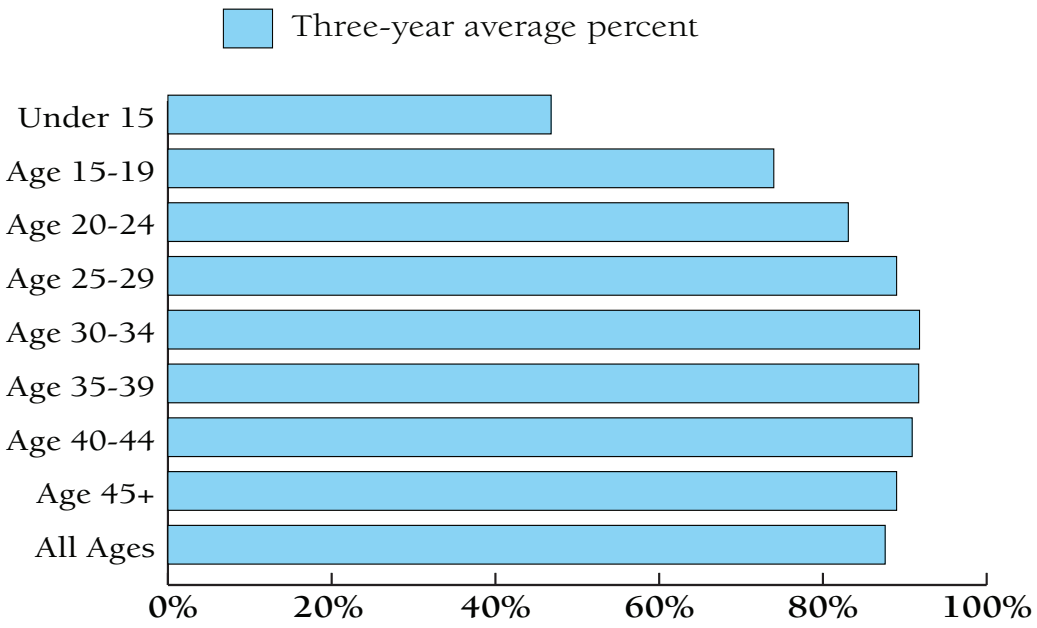
How are we doing?

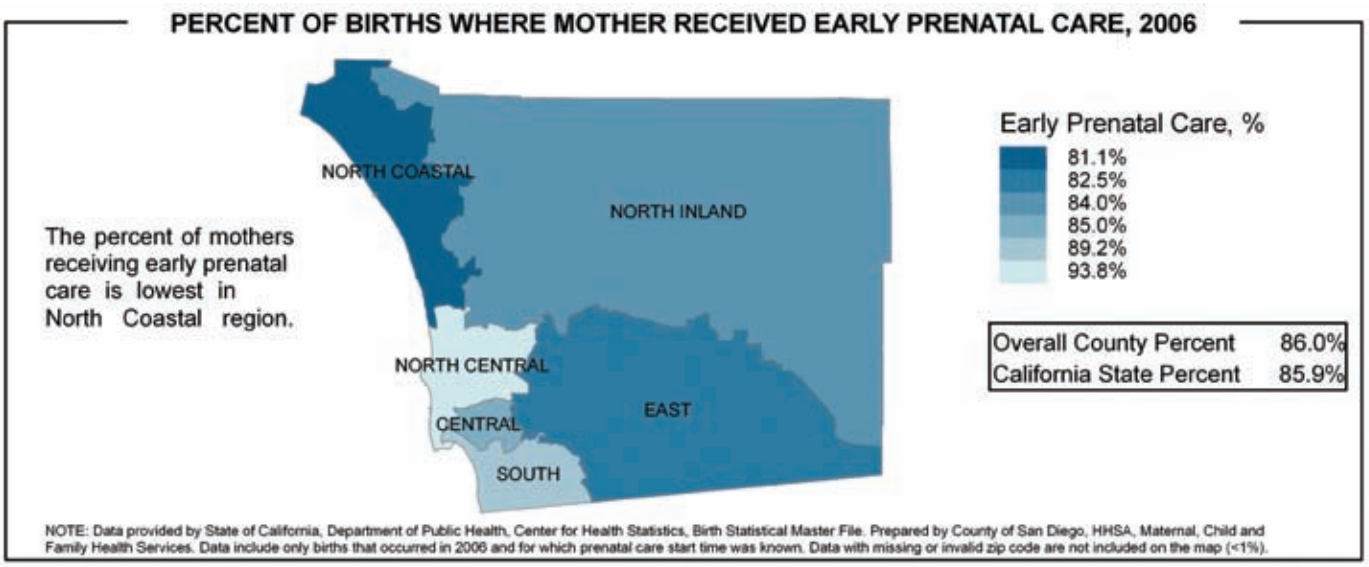
Percent of Mothers Receiving Early Prenatal Care, San Diego County and California Compared to National Objective, 2000-2006



San Diego has room for improvement. While the trend is improving — a higher percentage of mothers (86%) received prenatal care in 2006 than in 2000 (83%) — more needs to be done to meet the national objective of 90%. San Diego is doing better than the state average.

Percent of Mothers Receiving Early Prenatal Care, By Age, San Diego County, Three-Year Average 2003-05





Those groups likely to begin care after the first trimester and late in their pregnancy include: teen, African-American, Hispanic, and Pacific Islander. Asian and white mothers have the highest percentage (91% in 2006) of beginning care early.

What strategies can make a difference?

There are many factors that can affect whether or not a pregnant mother receives early prenatal care. An Institute of Medicine report identified four categories of barriers. First, financial barriers due to lack of health coverage still affect many near poor, working families. Second, the context of care has a significant impact (e.g., negative attitudes of health care providers, long waits after arriving for appointments, lack of cultural competence). Third, the accessibility of care (e.g., transportation, problems getting an appointment, inconvenient hours) makes a difference. Last, but not least, personal attitudes and behaviors (e.g., ambivalence about the pregnancy, lack of understanding about the importance of prenatal care) are barriers of timely prenatal care. What works best is high quality, accessible care, appropriate to address a woman's medical and psychosocial needs.

The following strategies have been used across the country to increase use of prenatal care:

- Removing financial barriers through expanded eligibility for health coverage, typically using public subsidies to make insurance affordable (e.g., Medi-Cal, Healthy Families).
- Improving the context of care by making prenatal clinics more user friendly (e.g., accessible by public transportation, flexible service hours, culturally competent staff).
- Using approaches such as "Centering Pregnancy," a program developed in California, which uses group care sessions to reduce costs while providing more care.
- Assuring comprehensive care (e.g., the California Comprehensive Prenatal Care Services package), which incorporates education and counseling.
- Using outreach and home visiting to support and connect socially isolated women to services.
- Helping with transportation problems, such as vouchers for public transportation or taxis.
- Improving the cultural competence of prenatal care.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with community clinics, hospitals, health care providers, faith communities and Health and Human Services Agency to:

1. Improve continuity of care for women with Presumptive Eligibility through increased education, improved turnover time with applications, and physician incentives to extend Presumptive Eligibility until Medi-Cal determination is made.
2. Explore methods to expand the availability of transportation vouchers in low-income communities to assist pregnant women in reaching community clinics and other prenatal care providers.
3. Adopt the "*Centering Pregnancy*" (group prenatal care and education) approach in community clinics, including culturally competent practices.

"Every woman who is planning a pregnancy should see her health care provider for a preconception check-up." *March of Dimes*

Birth to Age 3 (Infants and Toddlers): LOW BIRTHWEIGHT

What is the indicator?

The percent of infants born at low birthweight.

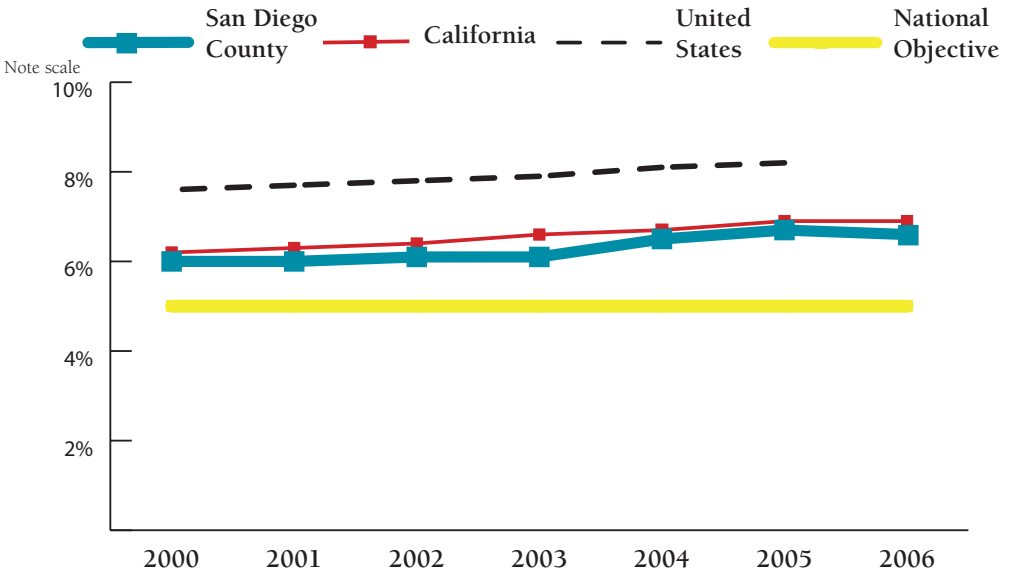
This indicator — the percent of infants born at low birthweight — is defined as weighing less than 2500 grams (5.5 lbs) and very low birthweight is defined as weighing less than 1500 grams (2.5 lbs) at birth. Both are included in this measure. These data are recorded on birth certificates and reported as part of local, state, and federal vital statistics.

Why is this important?

Babies born at low birthweight face twenty times the risk of dying in their first year of life. Low birthweight is often the result of premature birth, and together low birthweight and prematurity are the leading cause of infant mortality. With neonatal intensive care services, many of these babies who are born too soon and too small now survive, but for many of those who do, risks to health and development continue. Low birthweight can lead to multiple health problems such as poor lung development, cerebral palsy, learning disabilities, and behavior disorders.

How are we doing?

Percent of Infants Born at Low Birthweight, San Diego County, California, and United States Compared to National Objective, 2000-2006



The trend is moving in the wrong direction. In San Diego, as elsewhere in the nation, the proportion of babies born at low and very low birthweight is increasing. While better than most large urban areas, San Diego still needs improvement. Our rate is slightly better than the state average, but moving away from the national objective.

Percent of Infants Born at Low Birthweight, By Race/Ethnicity, San Diego County, Three-Year Averages 2002-04 and 2004-06

Race/ethnicity	Percent	
	2002-04	*2004-06*
African-American	11.3	11.4
Asian	7.4	7.4
Pacific Islander	7.2	6.6
Native American	5.9	6.9
Hispanic	5.4	5.7
White	5.9	6.4

Consistent with national trends, African-American women in San Diego County experience the highest rate of low-birthweight birth. In San Diego teen mothers and mothers over 35 are more likely to have low-birthweight babies.

What strategies can make a difference?

While the precise causes of low birthweight and prematurity continue to be studied, we can identify and reduce some of the contributing risks. Smoking and poor nutrition are two of the most widely known factors associated with low birthweight. Other biomedical risks include certain infections, periodontal disease, and diabetes. Very young teen mothers (under age 15) who may not be physically mature enough for childbearing and women who have multiple births (twins, triplets, etc.) are more likely to have babies born at low birthweight. Women who receive late or no prenatal care also are more at risk, because of untreated conditions. Since the most reliable predictor for a low-birthweight birth is a prior low-birthweight birth, experts recommend intervening between pregnancies to reduce risks.

The following strategies have been used across the country to reduce low-birthweight births:

- Getting women into prenatal care early and often to screen for infections, complications, and other risk factors.
- Increasing awareness of risks for pregnancy complications such as use of alcohol or drugs, smoking, certain prescription drugs, sexually transmitted infections, hypertension, and diabetes.
- Reducing smoking and exposure to secondhand smoke before and during pregnancy.
- Reducing stress and exposure to violence.
- Promoting proper nutrition and healthy weight before and during pregnancy.
- Reducing teen pregnancy.
- Promoting health and reducing risks before and between pregnancies (known as preconception and interconception care).

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with community clinics, hospitals, health care agencies and Maternal, Child and Family Health Services to:

1. Develop an interconception (between births) care initiative to provide augmented services for 24 months to the highest-risk, lowest-income women who have had a prior low-birthweight birth, miscarriage, or infant death.
2. Increase awareness of the importance of prenatal care, and identify and eliminate barriers to access.
3. Target smoking cessation programs, such as the National Cancer Institute's The 4 A's, to pregnant women.

"Breastfeeding exclusively for the first six months is a powerful way to get a newborn off to a healthy start in life." Tommy Thompson, former Secretary of Health and Human Services

Birth to Age 3 (Infants and Toddlers): BREASTFEEDING

What is the indicator?

The percent of mothers who initiate breastfeeding of newborn in hospital.

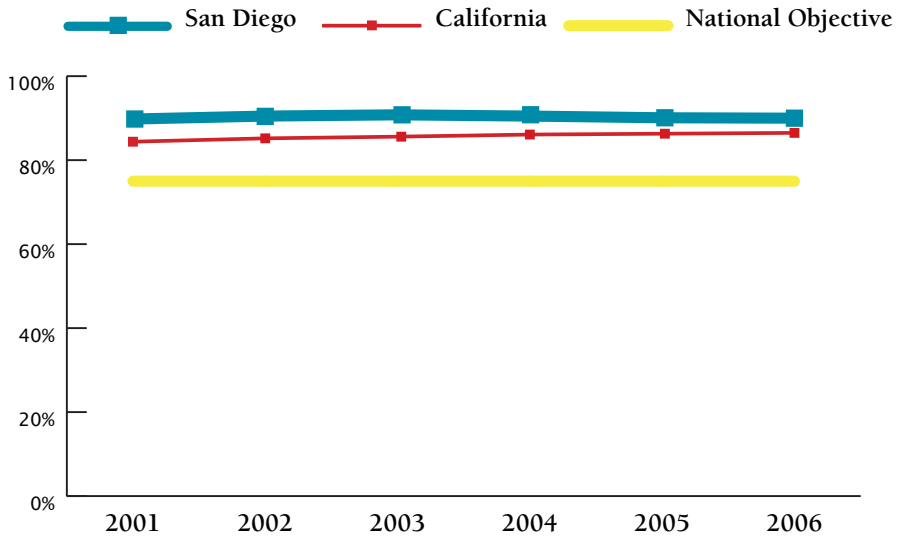
This indicator — the percent of mothers who initiate breastfeeding of newborn in hospital — estimates what proportion of infants receive breast milk. The data are collected on newborn screening forms and reported by the California Department of Health, including virtually all births in California (military hospitals and home births are excluded). National recommendations call for 6 to 12 months of breastfeeding, but data on continuation rates are available for only a small segment of the population.

Why is this important?

Breastfeeding is among the most effective and cost-effective preventive health practices. For children, it enhances immunity to disease and decreases the rate and severity of diarrhea, respiratory infections, and ear infections. It is associated with a reduced risk of Sudden Infant Death Syndrome (SIDS) and childhood obesity. Breastfeeding also may reduce lifelong risks for chronic health problems such as cardiovascular disease. Health benefits to the mother include reduced incidence of breast, ovarian and uterine cancer, quicker overall physical and emotional recovery after pregnancy, increased time between pregnancies, and reduced loss of bone density. Lastly, breastfeeding cost far less than formula.

How are we doing?

Percent of Mothers Who Initiate Breastfeeding of Newborn in Hospital, San Diego County and California Compared to National Objective, 2001-2006



The trend for breastfeeding initiation is improving gradually. San Diego County rates are better than the state average, with approximately 90% of mothers breastfeeding before they leave the facility where they gave birth to their baby. San Diego is exceeding the national objective.

What strategies can make a difference?

To improve maternal and child health, the American Academy of Pediatrics recommends exclusive breastfeeding for the first six months and support for breastfeeding till one year or even longer if desired. There are many educational, cultural, and social factors inhibiting the choice and ability to breastfeed and these need to be addressed in order to achieve an optimal rate. Factors that inhibit breastfeeding include the widely held belief that breastfeeding is difficult, challenges in continuing breastfeeding when the mother returns to work, aggressive formula marketing, lack of health education and support, and some medical conditions.

The following strategies have been used across the country to increase breastfeeding:

- Assuring that all birthing hospitals and centers encourage breastfeeding through programs such as "Baby-Friendly Hospitals," which support mothers in learning how to breast feed and promote exclusive use of breast milk.
- Ongoing culturally-informed education for mothers and health care providers.
- Offering workplace breastfeeding support (e.g., breaks and designated areas).
- Limiting the marketing of breast milk substitutes (i.e., formula).
- Improving public acceptance of breastfeeding, including more representation of breastfeeding in the media.
- Offering breastfeeding support and lactation education services, resources, and warmlines/help desks; and particularly through support and education from trained and experienced lactation consultants, home visitors, and/or nurses.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with local Chambers of Commerce, small businesses, small business associations, San Diego Workforce Partnership and their network of providers, hospitals, local Chambers of Commerce, Public Health and health insurance companies to:

1. Expand Baby-Friendly Hospital policies to birthing hospitals throughout San Diego County. Wellstart International, which is located in San Diego, California, developed the evaluation materials to support the Baby-Friendly Hospital initiative assessment process; however, few birthing facilities in San Diego are accredited Baby-Friendly Hospitals.
2. Increase the availability of lactation support to all mothers who need assistance via newborn home visits, telephone follow-up, warmline/help desk, and Women, Infants, and Children. This should include support and education from trained and experienced lactation consultants, home visitors, and/or nurses.
3. Conduct a campaign to improve workplace practices, allowing women time and space at work to support breastfeeding.

"Nearly 90% of teens say it would be easier to postpone sexual activity if they were able to have more open, honest conversations about these topics with their parents."

National Campaign to Prevent Teen Pregnancy

Birth to Age 3 (Infants and Toddlers): BIRTHS TO TEENS

What is the indicator?

The birth rate per 1,000 teens ages 15-17 years.

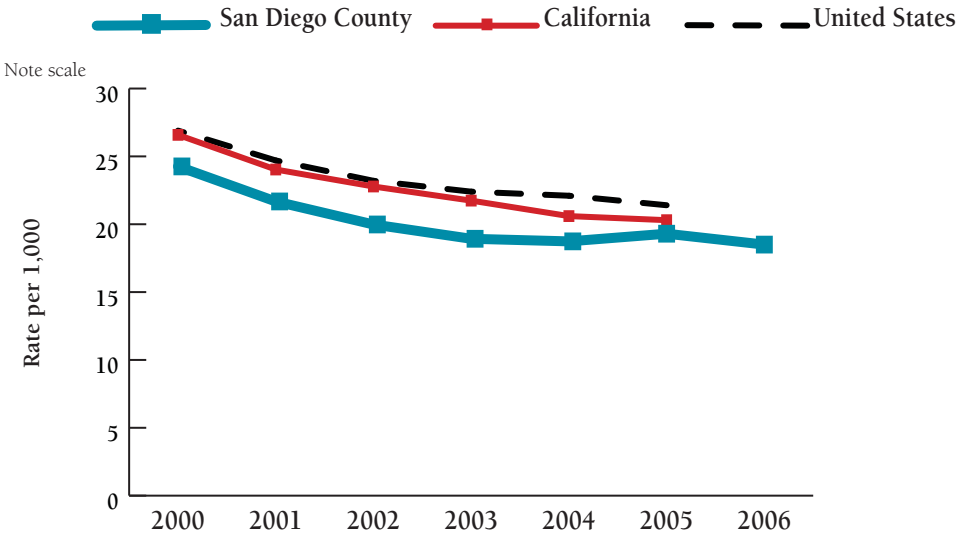
This indicator — the rate of births per teens age 15-17 years — monitors trends in birth rates for teens ages 15-17. Reliable data are available annually from birth certificates and reported as part of local, state, and federal vital statistics. It is not possible to get reliable data on the number of teens who become pregnant or are sexually active. Another reason to use births to teens as the indicator is that this measure is a better gauge of the number of teens who will be parenting.

Why is this important?

While rates are declining nationally, the United States still has the highest teen pregnancy rate of any industrialized country, and California continues to have one of the highest rates of any state in the country. Teens are generally unprepared for the responsibility of pregnancy and parenting. They are less likely to obtain early prenatal care and nutrition, and more likely to continue unhealthy behaviors, placing the baby at risk for future developmental and health problems. Teen parents are less likely to complete their education, and thus are at greater risk of earning below poverty incomes. Their babies are at greater risk for neglect and abuse. Thus, teen parenthood places two generations at risk.

How are we doing?

Birth Rate per 1,000 Teens Ages 15-17, San Diego County, California, and United States, 2000-2006



The trend is improving, dropping from 29 per 1,000 in 1997 to 19 per 1,000 in 2006. Most of this decline occurred prior to 2002, however, and progress has leveled off in the last 3 years. Overall, births to teens declined in San Diego over the last 10 years, as in California and the United States. San Diego's rate is better than the state and national averages.

What strategies can make a difference?

There is no single intervention that is effective for the complexity of factors that impact teen pregnancy. Best practices must be broad based and across systems that include: comprehensive education, early prevention services and activities, age appropriate intervention, and teen and family support.

The following strategies have been used across the country to decrease teen births:

- Promoting positive family involvement, including supervision, goals, and expectations. Teens who report a good relationship with their parents are less likely to engage in this and other risky behaviors.
- Involving boys in discussion and education; one of the most significant factors in the reduction of teen pregnancy is increased education and pregnancy prevention information for boys.
- Teaching healthy life skills and reproductive health education in schools.
- Providing after-school programs and activities to engage teens in the critical hours. Youth who attend after-school programs and/or engage in other after-school activities (e.g., sports, art, music) are less likely to engage in risky behaviors such as sexual activity and more likely to adopt positive future life plans.
- Prioritizing groups at special risk and involving community members to increase cultural relevance.
- Providing access to reproductive health services, including abstinence education and, for those approximately 60 percent of teens who become sexually active before high school graduation, contraceptive education and family planning services.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with community clinics, hospitals, health-related organizations, health care providers and schools to:

1. Expand pregnancy prevention programs such as the UCSD BRIGHT Families mentoring project in high-risk communities.
2. Expand health services that counsel teens regarding abstinence and contraception to help teens to make safe and healthy choices.
3. Provide ninth grade students with comprehensive family life and reproductive health education using evidence based curricula including: Be Proud! Be Responsible!, Becoming a Responsible Teen, Focus on Kids, Safer Choices, etc., and provide school-based health services.

"Few interventions in Public Health or preventive medicine can compare with the impact of the childhood immunization program." *Centers for Disease Control and Prevention*

Ages 3–6 (Preschool): IMMUNIZATION

What is the indicator?

The percent of young children (ages 19-36 months) who completed the basic immunization series.

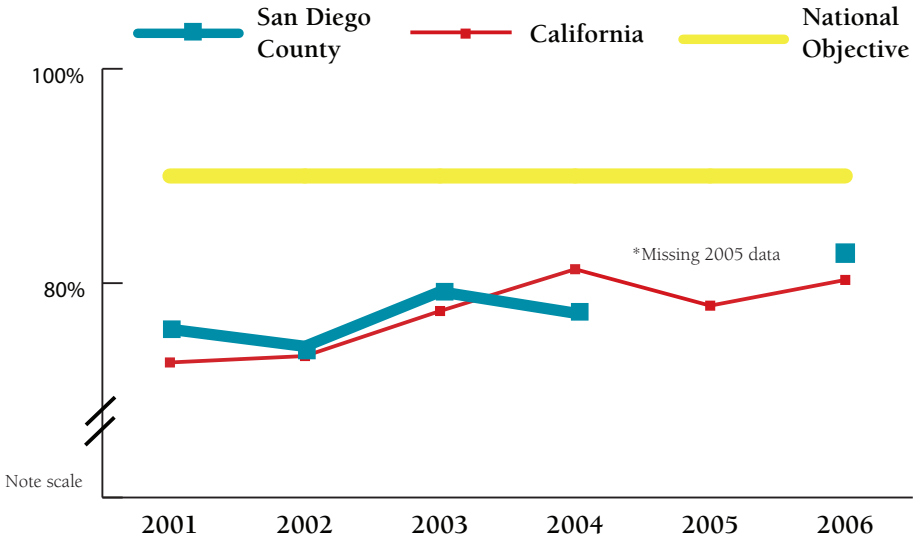
The childhood immunization indicator is the percent of young children (ages 19-36 months) who have received the basic recommended childhood immunization series. While the basic series of vaccines are due by age 24 months, no data exist to track for children precisely that age. These data are routinely collected through the National Immunization Survey, U.S. Centers for Disease Control and Prevention (CDC).

Why is this important?

Childhood immunizations are highly effective and cost-effective. A recent analysis of vaccines protecting against 10 diseases routinely administered to children estimated that $9.9 billion in direct costs and $43.3 billion in total costs are saved for each birth cohort of children vaccinated. This success is the result of a massive public/private partnership involving researchers, vaccine manufacturers, policy makers, public and private health professionals who administer vaccines, and, of course, families who voluntarily participate in immunization programs.

How are we doing?

Percent of Young Children (Ages 19-36 months) Who Completed the Basic Immunization Series, San Diego County and California Compared to National Objective, 2001-2006*



While the trend is gradually improving in San Diego County, there is still work to be done. San Diego is currently slightly above the state average, but still below the national objective.

What strategies can make a difference?

Since a national measles epidemic in 1990-91 alerted the nation to pockets of under immunization among our youngest children, communities across the country — including San Diego County — have given attention to this issue. Assuring appropriate immunization requires awareness, financing, provider access, and vaccine distribution systems that work effectively and efficiently.

The following strategies have been used across the country to increase immunization:

- Assuring an adequate supply of affordable vaccine. In terms of the basic early childhood series, this has largely been accomplished through the federal Vaccines for Children (VFC) program.
- Implementing immunization registries, which monitor who is up-to-date and who has missed vaccinations.
- Reaching out and providing support for families whose children are not up-to-date for recommended vaccines.
- Prioritizing groups at special risk and involving community members to increase the cultural relevance and cultural competence of programmatic efforts.
- Using community-wide campaigns and education to inform parents about the importance of immunizing "every child by two" and the continued risk of vaccine-preventable disease.
- Providing access to vaccines through pediatricians, family physicians, local health departments, community clinics, and other locations.
- Educating health providers about the importance and acceptability of giving vaccines, even at times when a child is mildly ill or at an office visit that is not a well child visit.
- Protecting providers who deliver vaccines from excessive liability costs and concerns by continuing the National Vaccine Injury Compensation Program.

How can we improve the trend in San Diego County?

We have made progress in the past decade, but more can be done to achieve the national objective. The San Diego County Immunization Initiative (I-3) is a local coalition of approximately 150 partner organizations working with the Health and Human Services Agency to identify and develop strategies to raise immunization coverage. The County also has an immunization registry that can help identify when children are not up-to-date on their vaccinations.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the San Diego County Immunization Initiative, American Academy of Pediatrics, First 5 San Diego, healthcare associations, community based organizations, faith communities and Public Health to:

1. Encourage the participation of all private pediatric primary care providers in the County immunization registry by streamlining procedures and providing no-cost training to office staff.
2. Educate health providers about giving vaccines, even at times when a child is mildly ill or at an office visit that is not a well child visit.
3. Partner with First 5 San Diego to develop a San Diego specific community-wide campaign, through WIC centers, infant-toddler child care, family resource centers, and other community settings that serve low-income and at-risk families to inform parents and caregivers about the importance of immunization.

"Experts tell us that 90% of all brain development occurs by the age of five. If we don't begin thinking about education in the early years, our children are at risk of falling behind by the time they start Kindergarten." *Robert L. Ehrlich*

Ages 3–6 (Preschool): EARLY CARE AND EDUCATION

What is the indicator?

The percent of children ages 3-4 enrolled in early care and education.

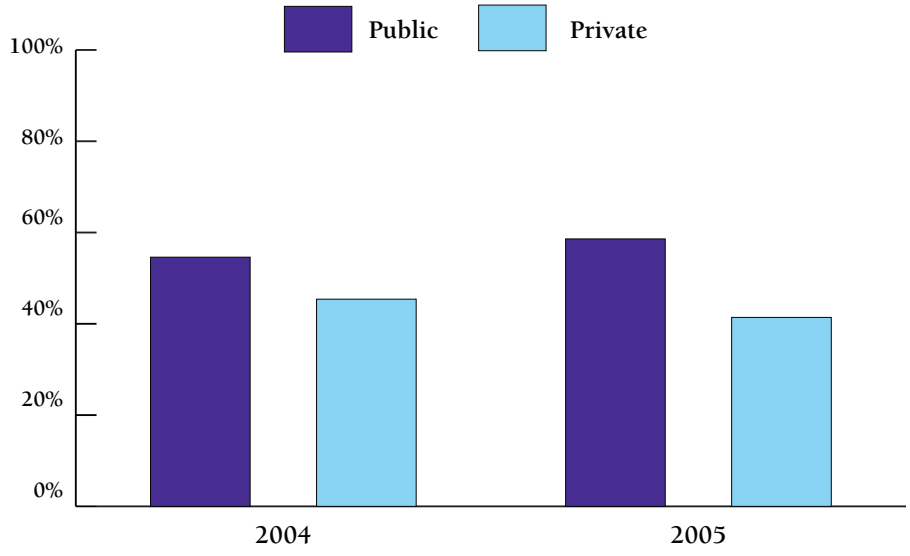
This indicator — the percent of children ages 3-4 enrolled in early care and education — shows trends in early childhood care and education for our County's preschool age children who are regularly attending an out-of-home and non-relative, early care and education setting. This setting may be a child care center, family child care setting (licensed or unlicensed), preschool, or Head Start program. The data is routinely gathered and reported by the U.S. Census Bureau American Communities Survey. Unfortunately, no data are routinely collected about early care and education for children ages 0-3.

Why is this important?

Much is known about how young children grow, develop, and learn. Recent brain research and other studies tell us we must provide environments that are nurturing and enriched beginning with babies. Research demonstrates that early childhood care and education in a quality setting (including child care, preschool, Head Start, etc.) can improve the school readiness and overall development of young children. It also can improve their education, employment, and positive outcomes throughout life. Thus, quality early care and education from birth to five years can not only help a child, but also produce economic benefits to society that far exceed the initial investment.

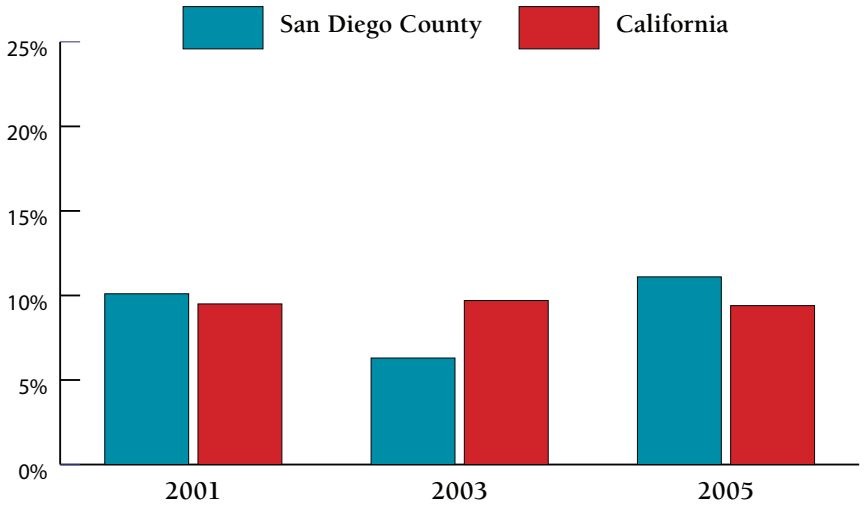
How are we doing?

Percent of Children Ages 3-4 Enrolled in Early Care and Education, San Diego, By Public and Private Enrollment, 2004 and 2005



In 2005, 53% of 3 and 4 year olds were enrolled in an early care and education setting, an increase from 43% in 2004. The percent of 3 and 4 year olds in San Diego who are enrolled in an early care and education setting is above the state (47%) and national (45%) averages.

Percent of Families Unable to Find Child Care for One Week or More, Children Ages 0-5, San Diego County and California, 2001, 2003, and 2005



The San Diego Child Care and Development Planning Council 2005 Needs Assessment found some areas remain underserved, with low-income and new immigrant families having less access to out-of-home child care. It also noted that finding child care for infants and toddlers (age birth to three) is particularly challenging.

Many young children in working families spend several hours each day in out-of-home child care. The availability of child care affects children, families, and the community on three levels. First, quality child care can have a significant impact on children's development in all domains (cognitive, language, social-emotional, and physical). Second, whether or not a family has adequate child care will affect one or both parents' ability to work, as well as the type of employment they are able to seek. Third, the effects on parental employment and the contribution of the child care sector contribute to our community's economic development. Notably, securing access to child care is a challenge for many families and a major expense for most families. Even two-wage earner families with both parents earning minimum wage typically spend 25% of their income on licensed child care for one preschool child.

What strategies can make a difference?

Over the past three decades, the economic and developmental impacts of early care and education have been extensively studied. Recently, experiments around the country have demonstrated how to improve the quality and availability of child care, particularly for the youngest children. Other efforts are aimed at assuring every child has an early care and education experience that fits their needs.

The following strategies have been used across the country to increase the percent of children attending early care and education settings:

- Implementing quality rating systems to give families information they need to identify quality programs.
- Providing child care subsidies for low-income families is essential for assuring access to quality early care and education.
- Adopting teacher training and credentialing standards, which are strongly associated with better outcomes for children.
- Offering child care resource and referral lines or centers that assist families in finding services that meet their needs.
- Providing technical assistance to family day care centers to insure good quality care and financial sustainability. For example, public/private funding partnerships such as the California Child Care Initiative Project develop family child care homes and provide training and supports that assure quality.
- Applying the Head Start and Early Head Start comprehensive models to other early care and education settings.
- Training and deploying child care health and mental health consultants to provide supportive services to children in early care and education settings.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with child care resource and referral agencies, early care settings, child care centers, public health, community colleges and universities, faith communities, Health and Human Services Agency, Behavioral Health Services, and mental health service providers to:

1. Increase the amount of available child care subsidies so that more low-income and working poor families have access to quality child care, particularly for infants and toddlers.
2. Train and fund more health and mental health consultants to provide services to children in early care settings and to work with staff to improve the quality of early care and education settings.
3. Improve the quality of child care by providing more training opportunities and support for child care providers, as well as facilities improvements and educational materials.

"What amounts to a 'silent epidemic' of dental and oral diseases is affecting some population groups." David Satcher, former U.S. Surgeon General

Ages 6–12 (School Age): ORAL HEALTH

What is the indicator?

The percent of children ages 2–11 who have never visited a dentist.

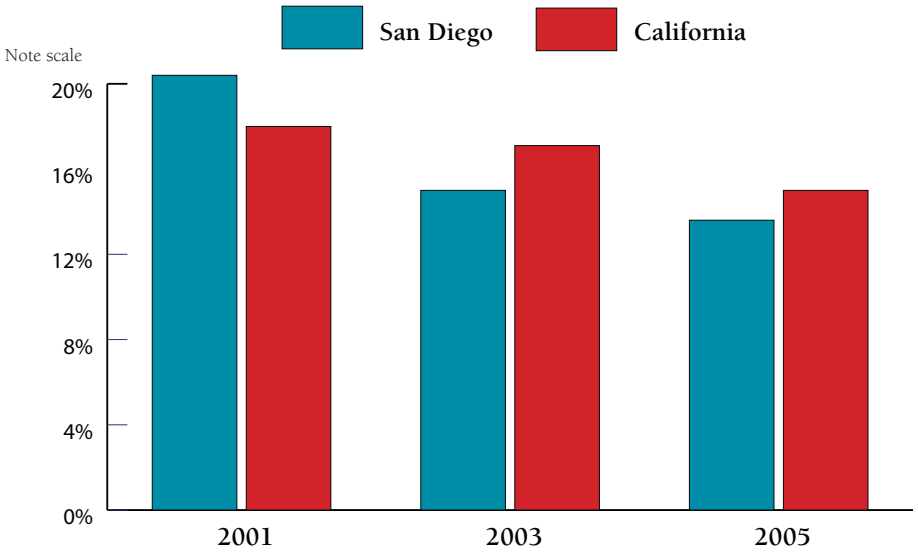
The indicator for oral health is the percent of children ages 2–11 who have never visited a dentist. This age range represents the most important years to prevent and treat dental disease and decay. Current national recommendations from dentists and pediatricians call for dental care to start at 12 months, and federal regulations call for children in Medi-Cal to be referred for dental care starting at age 24 months. These data are routinely reported in the California Health Interview Survey.

Why is this important?

Routine and preventive dental care is essential to: 1) educate about the importance of oral health practices at home, 2) apply protection such as fluoride treatments and sealants, and 3) provide intervention for dental caries (the disease that causes cavities). Dental caries is the single most common chronic disease of childhood. One-quarter of U.S. children — mostly poor, minority, and/or with special health care needs — experience 80% of all decayed teeth. Even decayed "baby" teeth affect child health and development of adult teeth. Children with untreated cavities often live with pain, which impedes concentration, school achievement, mood regulation, sleep, nutrition, and even play.

How are we doing?

Percent of Children Ages 2-11 Who Had Never Visited a Dentist, San Diego County and California, 2001, 2003, and 2005



The trend is improving. The percent of San Diego County children ages 2–11 who have never seen a dentist is close to the state average. Still, more than one in eight of our preschool and school age children have never had a dental visit.

What strategies can make a difference?

Dental care is an integral part of a complete health care system and important for assuring good oral health. Experts tell us that the key elements for assuring optimal oral health in children are: 1) sound nutrition, 2) effective "self-care" practices (e.g., brushing and flossing), and 3) access to dental prevention and treatment services through a "dental home" beginning at age two.

The following strategies have been used across the country to achieve success in improving the oral health status of children:

- Increasing children's coverage for dental services, particularly through Medicaid/Medi-Cal and Healthy Families.
- Increasing the supply of trained dental professionals, including dentists and dental hygienists. (This strategy includes increasing the number of training slots in higher education and offering loan repayment options in exchange for serving in low-income communities.)
- Expanding access to dental services in low-income and underserved communities (e.g., dental services in community clinics).
- Increasing effective use of primary health care providers (e.g., pediatricians), early childhood education (e.g., child care and Head Start), and other community organizations to educate parents about the importance of oral health and how to screen children for oral health problems.
- Assuring community water fluoridation.
- Implementing health promotion campaigns that increase families' awareness of the importance of brushing and flossing (from infancy), as well as preventive dental visits.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with Public Health, community clinics, health care agencies, American Academy of Pediatrics, dental associations, faith communities and local media partners to:

1. Assure that all children eligible for Medi-Cal coverage are enrolled using outreach for enrollment campaigns. (See health coverage indicator.)
2. Provide training to primary health care providers (e.g., pediatricians, nurse practitioners) and early childhood education providers (e.g., child care and Head Start) about how to educate parents about the importance of oral health and how to screen children for oral health problems, for example the American Academy of Pediatrics Bright Futures program.
3. Expand capacity in the "dental care safety net," including placement of dentists in community clinics, mobile dental services, and prevention services in early care and education settings, elementary schools, and after school programs.

"Truancy and excessive absenteeeism cause costly, long-term problems for students, schools, and the community." *California Department of Education*

Ages 6–12 (School Age): SCHOOL ATTENDANCE

What is the indicator?

The percent of elementary school (K-5) students who did not attend school at least 95 percent of school days.

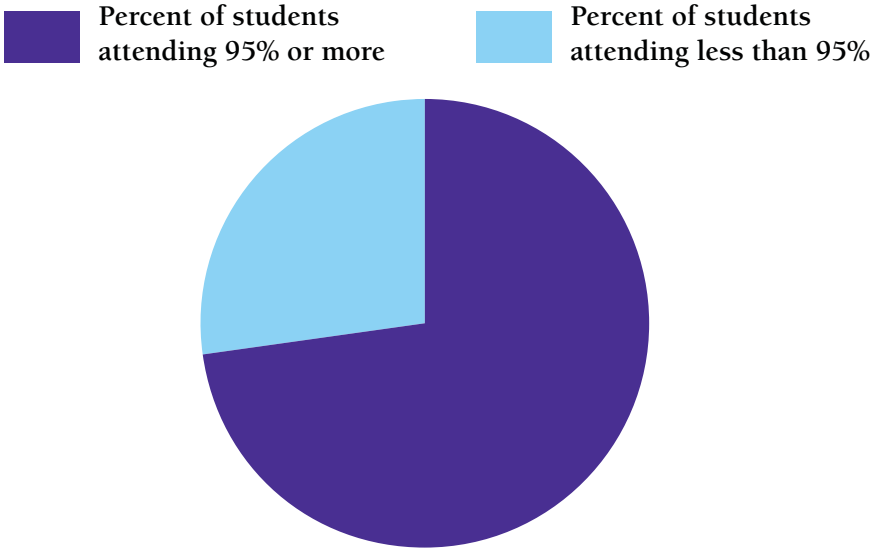
This indicator — the percent of elementary school (K-5) students who did not attend school at least 95 percent of school days — monitors school attendance based on 95 percent attendance on the Second Principal Apportionment (P2) reporting date of each district's school year. It includes students who are absent approximately nine days of the school year, for any reason. These data include school districts representing 90% of the student population, Note, this is not average daily attendance.

Why is this important?

School attendance is one of the strongest predictors of school success or failure. Students in elementary school are learning the basic reading, writing, math, reasoning, social and study skills that are critical to success and fulfillment in the higher grades. Without this foundation in place, the chances of graduating high school diminish with every year. Whether children miss school as a result of illness, family vacations, or truancy, missing many days of school affects learning. The U. S. Department of Education states that every school day missed requires two to catch up.

How are we doing?

Percent of Elementary School Students (Grades K-5) Who Did Not Attend at Least 95% of School Days, School Year 2006-07



In San Diego County, 27% of students in grades K-5 attended less than 95% of school days in school year 2006-07. Since this is the first year of collecting this data, no trend can be reported.

What strategies can make a difference?

There are many factors that may affect a child's attendance at school. National studies state that to address frequent absences and truancies, schools, parents, community prevention and intervention providers, and law enforcement must work together to develop policies, services, programs, and support for children and their families.

The following strategies have been used across the country to improve attendance rates:

- Developing and implementing sound, reasonable, and well-communicated attendance policies.
- Developing accurate and daily monitoring of attendance, with feedback to parents (e.g., using multiple languages, the Internet, email, and other forms of communication).
- Increasing parent and community awareness of the importance of regular attendance through education, outreach, and publicity.
- Providing positive reinforcement practices such as parent/student commendation letters and attendance rewards.
- Providing early interventions that address the specific cause of absenteeism, particularly with elementary school students and their families. Such efforts include family involvement programs and mentoring programs.
- Targeting interventions for students with chronic attendance problems, such as truancy reduction programs. This may come in the form of support for students who are struggling academically, experiencing depression, faced with bullying, etc. Linkages between schools, parents, health, and mental health professionals are an important element of efforts to reduce absenteeism.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with school districts, San Diego County Office of Education, California Department of Education, families, parent associations, community based organizations and local media partners to:

1. Develop a county-wide system to track individual student records longitudinally and across school/community transitions.
2. Start supportive interventions at the fifth absence including connecting with parents, assessing the child's issues and concerns and providing immediate individualized intervention services.
3. Increase community awareness and family engagement through approaches such as *Every Day Counts* or *Attendance Matters*.

"To learn to read is to light a fire; every syllable that is spelled out is a spark." *Victor Hugo*

Ages 6–12 (School Age): SCHOOL ACHIEVEMENT GRADE 3

What is the indicator?

The percent of students in grade 3 scoring proficient or advanced on the English Language Arts achievement test.

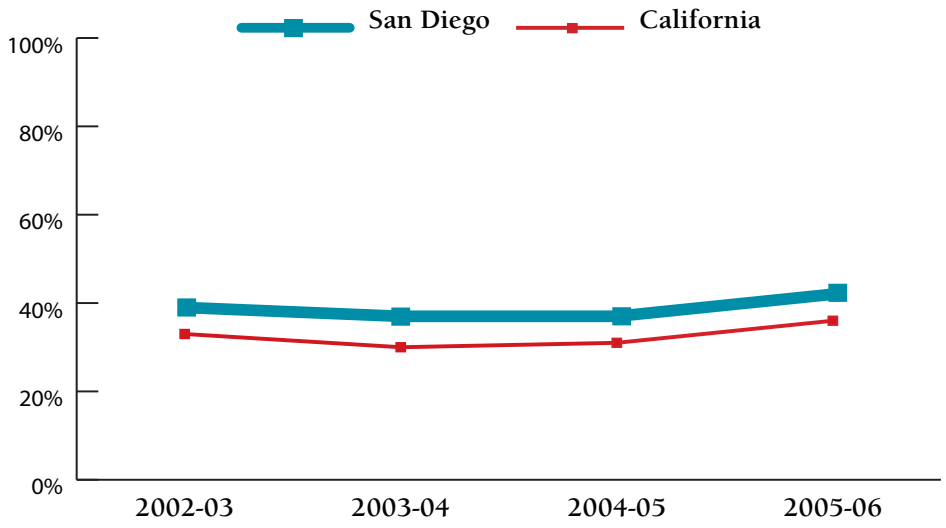
This indicator — the percent of students in grade 3 scoring proficient or advanced on the English Language Arts achievement test — measures students' scores on the English Language Arts test of the annual California Standardized Testing and Reporting (STAR) program. Administered annually to students in grades 2 through 11, STAR covers multiple subjects including English, Mathematics, Science, and History. These data are routinely reported by the California Department of Education.

Why is this important?

Performance on the English Language Arts test is widely accepted as the best predictor of school achievement overall, in part because mastery of English language skills is a critical foundation to understanding information taught about other subjects. Early attainment of basic English Language Arts skills is critical. In the primary grades, children are learning to read; but from that point on, they must read to learn. Moreover, poor readers are missing content learning that hinders them from learning other subjects. A child who does not master the basic learning skills does not have the foundation for future success.

How are we doing?

Percent of Students in Grade 3 Scoring Proficient or Advanced in English Language Arts Test, San Diego County and California, School Years 2002-03 to 2005-06



Between 2003 and 2006, the trend improved slightly, but not in a meaningful way (from 39% to 42%). Our county is slightly above the state average. Of concern is the fact that only 24% of Hispanic and 30% of African-American children are scoring proficient or advanced.

What strategies can make a difference?

The best approach to instilling English Language Arts skills and other reading skills is to begin early and to incorporate exposure, expectations, and education in all areas of a child's life. What children see and practice at home, what is included in their play and entertainment, and how skills are fostered at school; all of these affect learning skills and school achievement.

The following strategies have been used across the country to increase proficiency in English Language Arts:

- Providing parent literacy support and education, particularly on school campuses.
- Offering intensive English Language Arts instruction including: phonics based instruction, word/language study, small group instruction, and use of interesting and relevant reading materials.
- Developing appropriate intervention programs, including before and after school, summer and in-school reading support.
- Promoting independent reading and writing — at home and at school.
- Supporting reading across the curriculum in schools.
- Limiting time with television and video games.
- Providing mentors and tutors for children who have started to fall behind in English Language Arts and learning.
- Targeting services for parents of young children who do not speak English or who speak English as a second language.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, First 5 San Diego, California Department of Education, literacy and reading support organizations, parents and parent associations to:

1. Expand the use of special reading programs that support early childhood and family literacy, such as *Raising a Reader* or *Reach Out and Read*.
2. Develop a standardized, countywide kindergarten entrance assessment of school readiness, including a plan for immediate intervention when children lack basic pre-reading skills.
3. Provide early reading intervention instruction through programs such as *Reading Recovery, UROK, LindaMood-Bell*, and other one-to-one or small group intensive interventions.

"Physical fitness is not only one of the most important keys to a healthy body, it is the basis of dynamic and creative intellectual activity." ***President John F. Kennedy***

Ages 6–12 (School Age): OBESITY

What is the indicator?

The percent of students not in the Healthy Fitness Zone in grades 5 and 7.

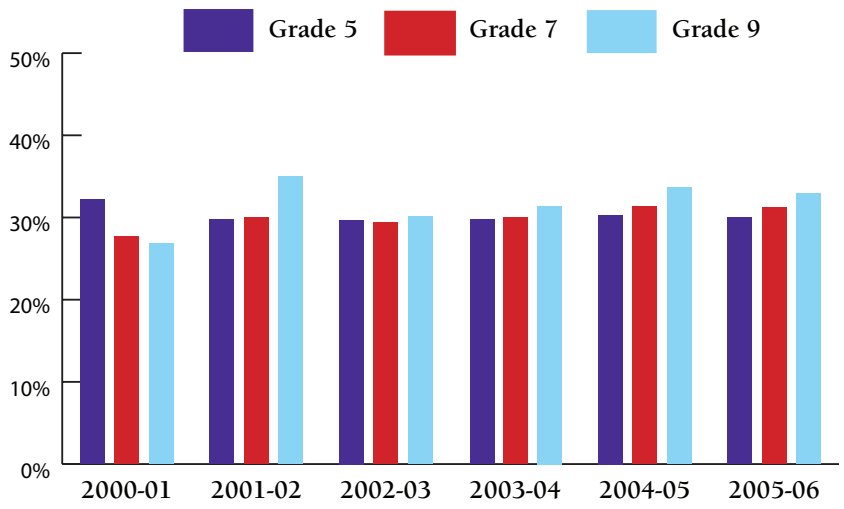
This indicator — the percent of students not in the Healthy Fitness Zone in grades 5 and 7 — measures overweight and/or obesity. The California Fitness Exam is a test of physical fitness given to students in grades 5, 7, and 9 every year, and it assesses the "Healthy Fitness Zone" based on a measure of body composition and Body Mass Index (BMI). Students who score outside the upper end of a specified range are not in the Healthy Fitness Zone. These data are routinely reported by the California Department of Health.

Why is this important?

Being over healthy weight can have short and long term health consequences for children. Overweight and obese children are 75% more likely to be overweight and obese as young adults, as well as at increased risk for high blood pressure, high cholesterol, and Type 2 diabetes. In addition to the physical health risks, many overweight and obese children experience social discrimination and bullying. Obesity is one of the top 10 leading health indicators for the Healthy People 2010 National Health Objectives.

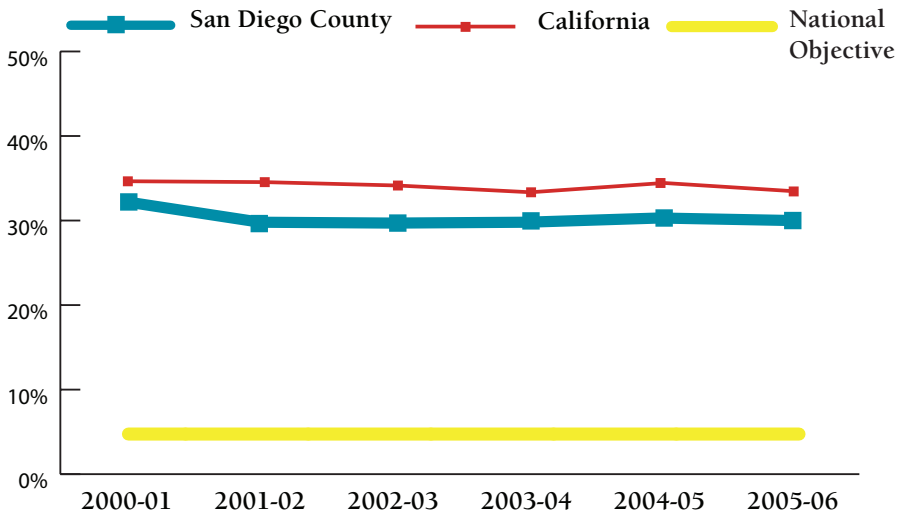
How are we doing?

Percent of Students Not in Healthy Fitness Zone, Grades 5, 7, and 9, San Diego County, School Years 2000-01 to 2005-06



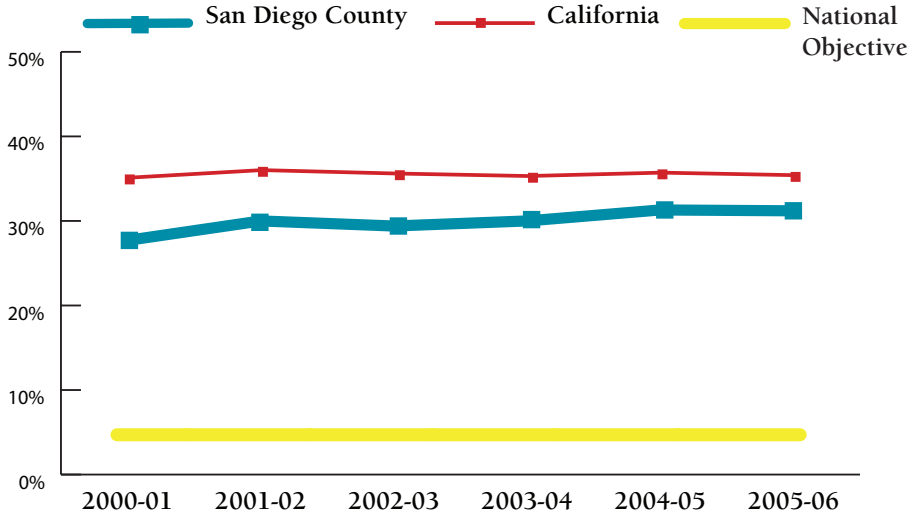
The trend is not improving. Although slightly below the state rates (not shown) for 5, 7, and 9th graders, San Diego is far from achieving the national objective of having no more than 5% of children and youth overweight or obese.

Percent of Students Not in Healthy Fitness Zone, Grade 5, San Diego County and California, School Years 2000-01 to 2005-06



The trend is not improving. Approximately 30% of our 5th graders are not in the Healthy Fitness Zone and have a BMI that places them at risk. Although only slightly below the state average for grade 5, San Diego is far from achieving the national objective of 5%.

Percent of Students Not in Healthy Fitness Zone, Grade 7, San Diego County and California, School Years 2000-01 to 2005-06



Again, the trend is not improving. Approximately 30% of our 7th graders are not in the Healthy Fitness Zone and have a BMI above levels for optimal health.

What strategies can make a difference?

Communities across the country are taking action to reduce weight issues among children. Prevention, shown to be more effective than intervention, should be a primary focus, as well as the impact of the physical environment, social norms and expectations, and access to better nutrition.

The following strategies have been used across the country to address weight and obesity issues:

- Increasing rates of breastfeeding.
- Developing fitness and weight assessments starting at kindergarten.
- Increasing healthy nutrition education and services to children and their parents.
- Increasing routine physical activity for children in and out of school.
- Providing extended hours and nighttime lights and security at public parks, sporting complexes, school fields, and community recreation centers.
- Reducing access at school to soft drinks, candy, and other foods high in calories, while low in nutrition.
- Expanding the availability and affordability of fresh fruits and vegetables in schools at all grades and in low-income neighborhoods.
- Requiring that public vending machines and snack bars have nutritious selections (water, fruit, low-fat and low-calorie snacks).
- Providing nutrition and physical fitness education in health care and education settings.

How can we improve the trend in San Diego County?

Several years ago the San Diego County Board of Supervisors voted to support the creation, coordination, and implementation of a childhood obesity master plan. The Obesity Initiative Leadership Council was formed and with community involvement and stakeholder input a *Call to Action: Childhood Obesity Action Plan* was developed. This plan is the beginning of a countywide, cross system, coordinated effort to address legislation, local policies, programs, and services that impact childhood obesity.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with community based organizations, neighborhood associations, San Diego Childhood Obesity Initiative, County of San Diego, San Diego County Office of Education, schools and school districts, First 5 San Diego, and faith communities to:

1. Assist schools in implementing federally mandated "School Wellness Policies" and in developing plans that include the incorporation of daily exercise into the school day, the elimination of sodas and unhealthy snacks, and the provision of nutritious meals and snacks.
2. Expand healthy nutrition classes and education at community clinics, WIC centers, early care and education settings, and community centers.
3. Support the development of farmer's markets and school and community gardens, particularly in low-income neighborhoods.

"We must give our students a sense of brotherhood and belonging in our schools, so they do not look for it on the street corners." *Rod Paige, U.S. Secretary of Education*

Ages 13–18 (Adolescence): SCHOOL ATTENDANCE

What is the indicator?

The percent of middle and high school students (grades 6-12) who did not attend school at least 90 percent of school days.

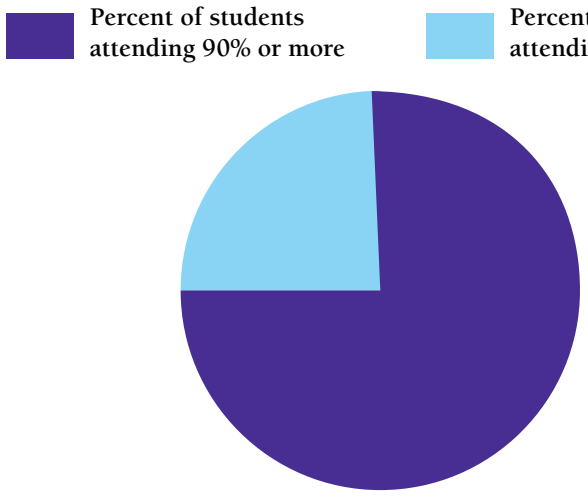
This indicator — the percent of middle and high school students who did not attend school at least 90 percent of school days — monitors school attendance based on 90 percent attendance on the Second Principal Apportionment (P2) reporting date of each district's school year. It includes students who are absent approximately 18 days of the school year, for any reason. These data include school districts representing 90% of the student population, Note, this is not average daily attendance.

Why is this important?

School attendance is a very strong predictor of school success. Students who attend school 90% of the time have a much better chance of academic success, and academic success is strongly correlated with better employment and higher earnings. Students who attend regularly have stronger social relationships and connectedness to school. Chronically poor attendance is associated with lower achievement, lower test scores, literacy problems, and dropping out of school. Poor attendance is not just truancy-related. Whether children miss school as a result of illness, family vacations, substance abuse problems, or truancy, missing many days of school directly affects learning.

How are we doing?

Percent of Middle and High School Students (Grades 6-12) Who Did Not Attend at Least 90% of School Days, School Year 2006-07



In San Diego County, 24% of students in grades 6 to 12 attended school less than 90% of their school days in school year 2006-07. Since this is the first year of collecting this data, no trend can be reported.

What strategies can make a difference?

Best practices have demonstrated that to address attendance issues with middle and high school students we must bring together schools, parents, community providers, and law enforcement to develop policies, services, programs, and support that focus on both prevention and intervention services.

The following strategies have been used across the country to increase school attendance:

- Developing and implementing sound, reasonable, and well-communicated attendance policies.
- Developing accurate and daily monitoring of attendance, with feedback to parents (e.g., multiple languages, using the Internet, email, and other forms of communication).
- Designing targeted outreach and education campaigns highlighting the importance of regular attendance to communities, and families with high-risk students.
- Providing positive reinforcement practices such as parent/student commendations and attendance rewards.
- Providing early interventions that address the specific cause of absenteeism. Such efforts include family and caregiver involvement, tutoring programs, engaging students in service learning, and mentoring.
- Targeting interventions for students with chronic attendance problems, such as truancy reduction programs, smaller learning communities, and attendance intervention centers. This may come in the form of support for students who are struggling academically, experiencing depression, struggling with substance abuse, etc.
- Building linkages between schools, mental health providers, and law enforcement.
- Keeping the students safe and supported at school and on their way to and from school.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with school districts, San Diego County Office of Education, California Department of Education, San Diego Workforce Partnership, local businesses, law enforcement agencies, the Probation Department, families, parent associations, community based organizations, and local media partners to:

1. Develop a county-wide system to track individual student records longitudinally and across school/community transitions.
2. Start supportive interventions at the fifth absence including family and law enforcement outreach, assessing the student's issues and concerns, and providing immediate individualized intervention services including counseling and mentoring.
3. Increase student connections to school through the use of service learning, school to work opportunities, and career academies.

"Education should not be the filling of a pail, but the lighting of a fire." ***William Butler Yeats***

Ages 13–18 (Adolescence):

SCHOOL ACHIEVEMENT GRADES 8 AND 11

What is the indicator?

The percent of students in grades 8 and 11 scoring proficient or advanced on the English Language Arts achievement test.

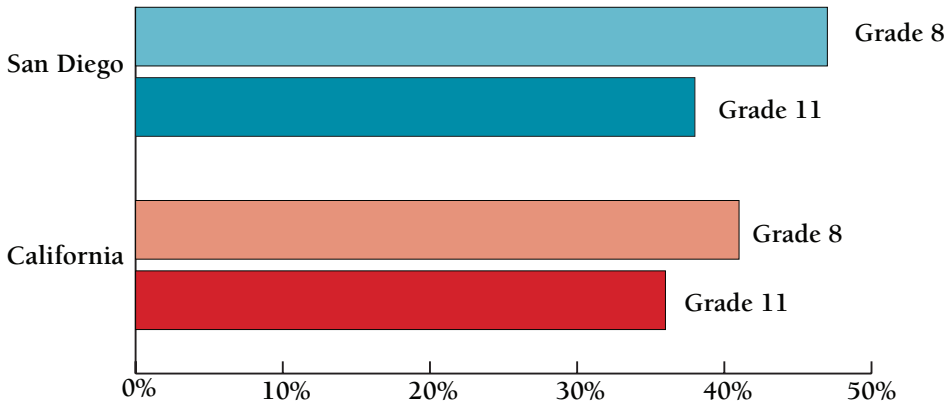
This indicator — the percent of students in grade 8 and 11 scoring proficient or advanced on the English Language Arts achievement test — measures students' scores on the English Language Arts test of the annual California Standardized Testing and Reporting (STAR) program. Administered annually to students in grades 2 through 11, STAR covers multiple subjects including English, Mathematics, Science, and History. These data are routinely reported by the California Department of Education.

Why is this important?

Reading and English Language Arts skills are one of the best predictors of school success and achievement, and low literacy is one of the greatest predictors of not finishing school. School success is a critical predictor of good outcomes in many vital areas of life. High school achievement is associated with positive self-image, resistance to delinquency, increased likelihood of graduation and college attendance, and higher earnings. Poor English Language Arts and reading skills are correlated with unemployment and poverty as an adult.

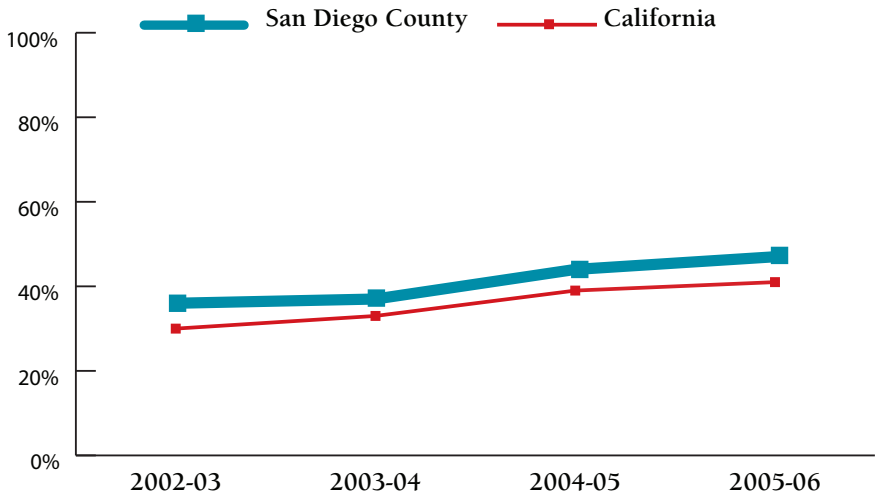
How are we doing?

Percent of Students Scoring Proficient or Advanced in English Language Arts Test, Grades 8 and 11, San Diego County and California, School Year 2005–06



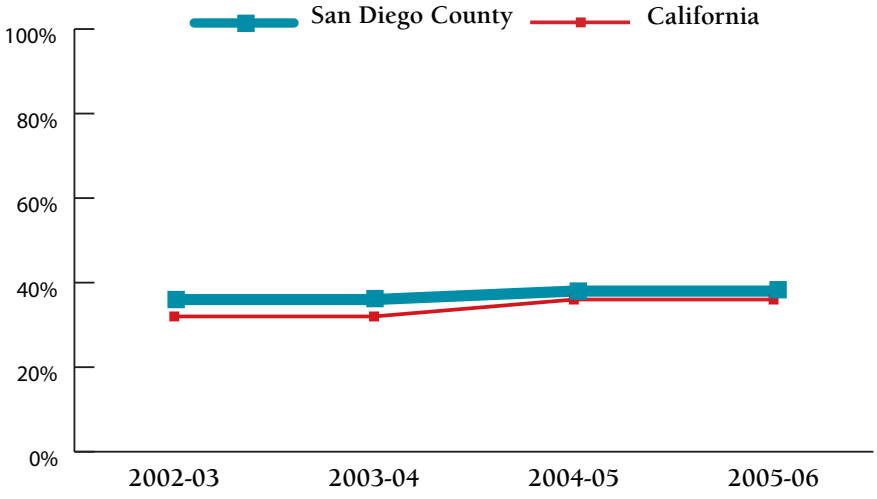
Younger students fare better than older students. While nearly half of our 8th graders are scoring proficient or advanced in English Language Arts, the percentage drops to 38% by 11th grade. San Diego student scores are higher than the state averages.

Percent of Students Scoring Proficient or Advanced in English Language Arts Test, Grade 8, San Diego County and California, School Years 2002-03 to 2005-06



The trend for San Diego County is improving substantially, going from 36% to 47% for 8th graders between school years 2002-03 and 2005-06.

Percent of Students Scoring Proficient or Advanced in English Language Arts Test, Grade 11, San Diego County and California, School Years 2002-03 to 2005-06



The trend for San Diego County is improving slightly, going from 36% to 38% for 11th graders between school years 2002-03 and 2005-06.

What strategies can make a difference?

Detection of learning and achievement problems and intensive intervention are critical at higher grades. As students enter middle and high school, feeling successful at school and connected to school becomes increasingly important for staying in school and graduating. Studies have shown that smaller learning communities can result in improved academic achievement, lower dropout rates, and narrowed achievement gaps for underprivileged students.

The following strategies have been used across the country to increase proficiency in English Language Arts:

- Increase students' feeling of connection to school.
- Encouraging reading and writing at school and at home (e.g., access to reading materials of interest, journal writing).
- Increasing focus on reading comprehension.
- Providing specialized reading trainings and instructional strategies for teachers and classroom support staff.
- Expanding and targeting supportive services to underperforming students (e.g., reading specialists, tutors, one-to-one instruction).
- Evaluating and addressing underlying issues of poor academic performance (e.g., substance abuse, mental health, safety concerns).
- Developing smaller schools, schools within school models, and industry specific academies.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego Workforce Partnership, local businesses and business associations, substance abuse prevention agencies, mental health service providers and literacy and reading support organizations to:

1. Develop smaller schools, schools within schools, and industry specific academies.
2. Provide academic intervention such as trained reading specialists and core academic tutors during the school day and in after school programs.
3. Provide social intervention services such as substance abuse counselors and mental health professionals to work with students during the school day and in after school programs.

"Teen smoking can signal the fire of alcohol and drug abuse or mental illness, like depression and anxiety." *Joseph Califano, former U.S. Secretary of Health and Human Services*

Ages 13–18 (Adolescents): SUBSTANCE ABUSE

What is the indicator?

The percent of students (grades 7, 9 and 11) who reported using cigarettes alcohol or marijuana in the past 30 days.

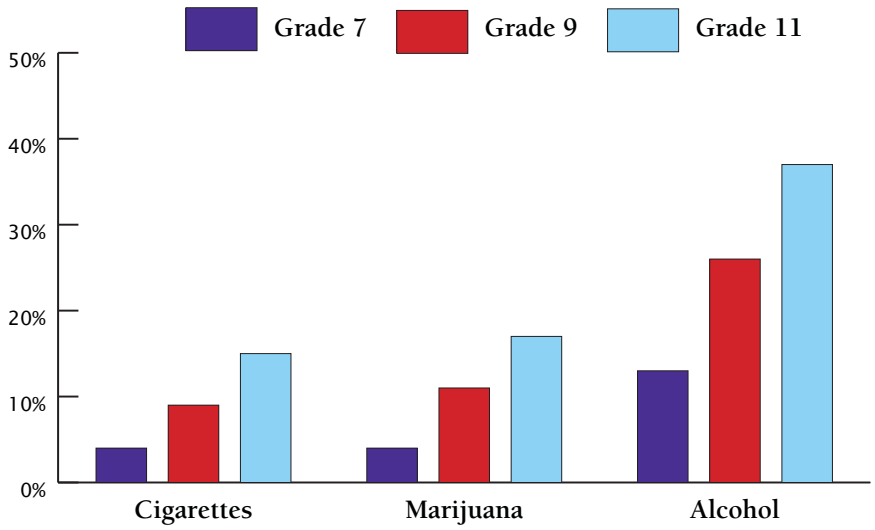
This indicator reports the percentage of students in grades 7, 9 and 11 who report having used cigarettes, alcohol, or marijuana in the last 30 days. These data are collected with the California Healthy Kids Survey, administered annually to students in grades 7, 9 and 11 throughout the state of California. These questions mirror the questions in the Youth Risk Behavior Survey, a CDC-designed survey in use across the country.

Why is this important?

The use of cigarettes, marijuana, methamphetamines and alcohol can stunt an adolescent's physical and mental growth and development. Studies show that prolonged use of alcohol and drugs can negatively impact academic success, relationships with others, job potential, and mental health. While the use of cigarettes, marijuana, and alcohol has decreased nationally since the late 1990s, areas for concern still exist. Misuse of presciption medications and drugs such as Ecstasy or methamphetimines is increasing. Compared to non-smokers, teens who smoke are five times more likely to drink and 13 times more likely to use marijuana.

How are we doing?

Percent of Students Grades 7, 9, and 11 Who Reported Use of Cigarettes, Marijuana, or Alcohol, San Diego County, School Year 2004-05



Older students are more like to use substances. The trend in San Diego County for all three substances reported here is improving, with student reports of substance use steadily declining since 1999. San Diego County students reported lower levels of use than the national average and comparable to state rates.

What strategies can make a difference?

To address substance abuse issues, strategies must focus on both prevention and intervention policies, services, and programs. Services are most effective when they are available immediately after identification of issue, community based, and holistic.

The following strategies have been used across the country to decrease young people's use of cigarettes, alcohol, and drugs:

- Increasing students' ability to resist social pressure to abuse cigarettes, alcohol, and drugs through school based programs such as life skills training.
- Teaching parents of preteens and younger adolescents the skills they need to improve family communication and bonding through programs such as *Guiding Good Choices*.
- Building resistance, resiliency, social competency, and problem solving skills.
- Promoting youth development including increasing connectedness to school.
- Enforcing local ordinances prohibiting the sale of cigarettes and alcohol to minors.
- Working with parents and community to educate about the dangers of substance abuse.
- Working with parents, schools, and community to eliminate youth access to cigarettes, alcohol, and drugs.
- Increasing availability of community based drug and alcohol treatment programs, both day treatment and residential.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, Alcohol and Drug Services, substance abuse prevention agencies, the Probation Department, community based organizations and faith communities to:

1. Promote youth development activities, after school programs and early prevention programs including: Community Assessment Teams, Friday Night Live, *Club Live*, *Botvin's Life Skills Training*, Critical Hours, and ASES and ASSETS after school programs.
2. Expand access to current Teen Recovery Centers and evaluate regional needs for additional locations.
3. Expand capacity for drug and alcohol residential services.

"Suicide shouldn't be a secret." ***American Foundation for Suicide Prevention, Youth Campaign***

Ages 13–18 (Adolescence): YOUTH SUICIDE

What is the indicator?

The percent of students who reported they attempted suicide in the previous 12 months.

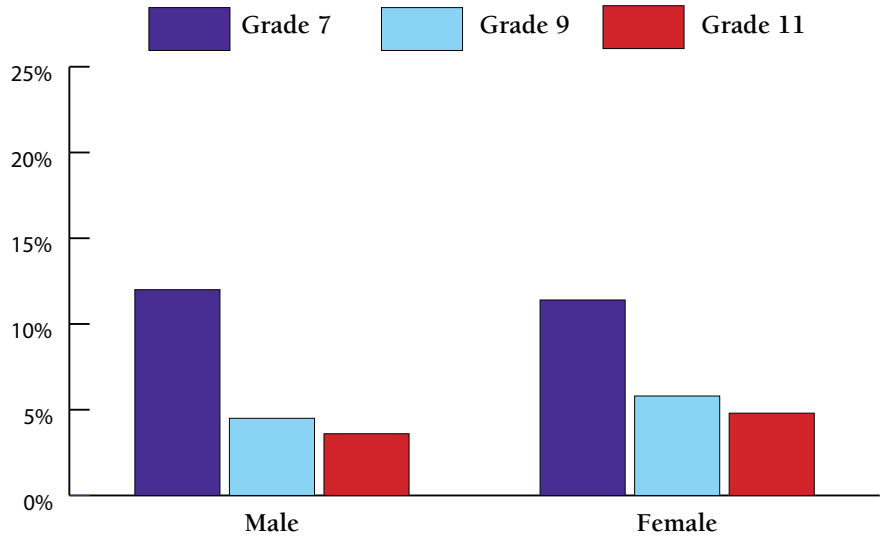
This indicator reports the percent of high school students who self report having made a suicide attempt in the previous 12 months. These data are collected and reported on Module G, part of the California Healthy Kids Survey, which is administered in secondary schools on an annual basis. Beginning in school year 2004-05, 12 out of the 18 unified and high school districts in San Diego County (including San Diego Unified) administered Module G as part of the survey.

Why is this important?

Over the past decade, suicide was a leading cause of death for San Diego County children and youth over age 10. Each year approximately 10-12 San Diego youth commit suicide. Other youth are hospitalized as a result of attempted suicide. In addition to the tragedy of death, suicide has a lasting emotional and even traumatic effect on the community, particularly family and friends. Survivors are left with emotions of guilt, grief, and confusion that can be debilitating. Perhaps most important is the fact that suicide is often preventable.

How are we doing?

Percent of Students Who Reported They Had Attempted Suicide in the Past 12 Months, By Gender, San Diego County, School Year 2006-07



About 11% of students reported having made one or more suicide attempts within the past 12 months. In 2006-07, 7th graders were twice as likely to report a suicide attempt as students in grades 9 and 11. Male and female students reported attempts at similar rates within each grade.

What strategies can make a difference?

Youth suicide prevention depends on community, family, and youth education. Youth typically do not contact professional help when they are depressed. Peers, teachers, health professionals, and parents are the people most likely to have contact with a depressed youth, and thus in the best position to intervene.

The following strategies have been used across the country to prevent youth suicide:

- Raising community and family awareness of the signs of depression and suicidal ideation (i.e., thinking about committing suicide).
- Emphasizing and reinforcing that suicide is preventable.
- Education for peers and adult "gatekeepers" (e.g., teachers, school bus drivers, coaches) to recognize the warning signs and risk factors associated with suicide.
- Reducing the stigma associated with seeking support and help for depression and other mental health problems.
- Education for parents and others about reducing access to lethal means, particularly firearms which are increasingly used by youth to attempt suicide.
- School-placed programs that promote help-seeking behavior, provide assessment, motivational counseling, problem-solving skills, and peer support, as well as reconnecting youth to their school and peer group.
- Training peers to respond to suicidal statements as an emergency, particularly to tell a trusted adult and use crisis hotlines.
- Interventions tailored to at-risk cultures/ethnicities.
- Increasing data acquisition to better identify populations at risk.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with school districts, San Diego County Office of Education, American Academy of Pediatrics, Behavioral Health Services, mental health service providers, parents, faith communities, community based organizations and suicide prevention programs to:

1. Provide education for families, caregivers, health care providers, educators, school staff, mental health providers, and peers about the warning signs and risk factors of depression and suicide, as well as protective factors that reduce the likelihood of suicide.
2. Support additional mental health training and services and access to a variety of clinical interventions, as well as programs which specifically focus on suicide prevention such as Yellow Ribbon Suicide Prevention Program, QPR-Question, Persuade and Refer, and Safe TALK: Suicide Alertness for Everyone.
3. Increase the number of school districts in San Diego County that administer suicide questions (Module G) as part of their California Healthy Kids Survey.

"Prevention is the real solution to crime among our youngest citizens."

Janet Reno, former U.S. Attorney General

Ages 13–18 (Adolescence): JUVENILE CRIME

What is the indicator?

The number of arrests for misdemeanor and felony crimes among youth ages 10-17.

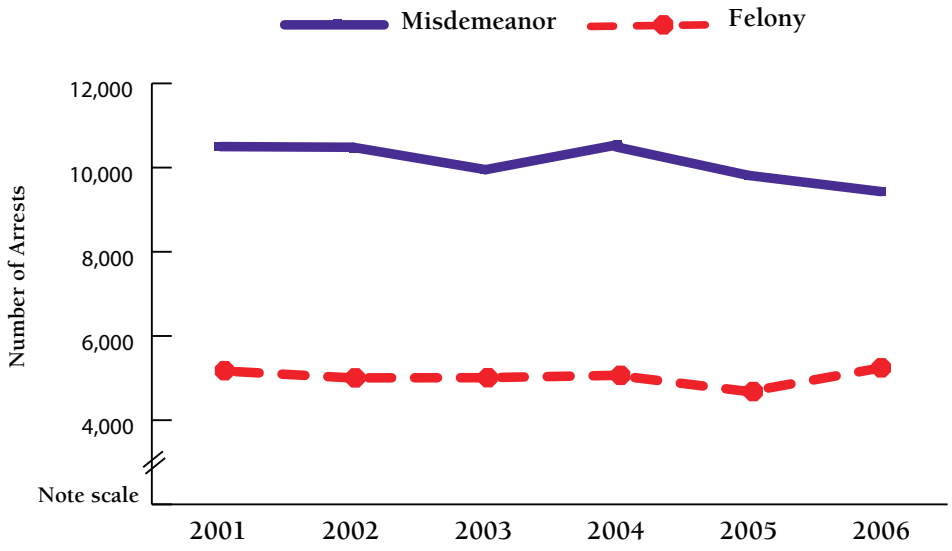
This indicator reports the number of arrests for misdemeanor and felony crimes among youth ages 10-17. Arrests for status offenses such as curfew violations or truancy are not included. One arrest may have more than one charge associated with it. Only the most serious offense is reported in each arrest. These data are collected by law enforcement, stored in Automated Regional Justice Information System (ARJIS), and routinely reported by SANDAG.

Why is this important?

Juvenile crime is costly on multiple levels. Primarily, there is the potential cost of a productive life for the young person. In addition, crime costs the community its sense of safety and it costs victims their property, money, health, and sense of well-being. Other costs to government, community and family include costs for the juvenile justice system, medical costs, work time, and property values.

How are we doing?

Number of Arrests for Felony and Misdemeanor Offenses, Youth Ages 10-17, San Diego County, 2001-2006



The number of juvenile arrests for felonies is not improving. The trend is improving for misdemeanor arrests — dropping slightly from over 10,500 in 2001 to about 9,500 in 2006.

RATE OF ARRESTS PER 1,000 YOUTH AGES 10-17, 2006

Escondido, located in North Inland region, has the highest rate of juvenile arrests.

Overall County Rate	50.6
California Rate	50.0

Rate of Juvenile Arrests

- 24.3 - 31.3
- 31.4 - 38.5
- 38.6 - 50.5
- 50.6 - 59.7
- 59.8 - 74.3
- Insufficient or No Data

SOURCES: CA Department of Justice, Criminal Justice Statistics Center; U.S. Census Bureau, Census 2000; CA Department of Finance, Revised E5 City/County Population Estimates, May 2006; SANDAG, Dempgraphic/Economic Estimates July 2007

NOTE: 2006 Juvenile Arrest data were provided by Automated Regional Justice Information System, ARJIS. Total includes felony, misdemeanor, and status offenses rates. Data represents location of arrest not residence of youth. Rates are based upon 2000 U.S. Census data and current California Department of Finance updates for population ages 10-17. Rates per 1,000 youth are not presented if number of arrests is less than 30.

What strategies can make a difference?

Studies show that identifying young people when they first begin to experiment with unhealthy and risky behaviors and providing them with programs that focus on prevention and early intervention service can keep them from entering the juvenile justice system.

The following strategies have been used across the country to decrease the incidence of juvenile crime:

- Providing quality after school programs for elementary, middle, and high school students.
- Providing substance abuse prevention and intervention programs.
- Expanding early mental health services.
- Offering literacy support, life skills training, vocational education, career development programs, internships and employment opportunities.
- Developing problem solving, anger management, mediation, and conflict resolution instruction.
- Expanding gang prevention programs to elementary and middle school youth.
- Supporting community policing practices.
- Developing and expanding Juvenile Diversion programs.
- Developing and implementing juvenile accountability practices that include skill building, reparation to victims, and community service.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Probation Department, local law enforcement agencies, community-based organizations, Juvenile Court, San Diego Workforce Partnership and their network of providers, parents and parent associations, faith communities, local businesses and business associations to:

1. Expand early prevention and intervention programs such as Community Assessment Teams, Juvenile Diversion, Truancy Intervention program, Critical Hours and after-school programs, and mental health programs such as Multi Systemic Therapy, and Assertive Community Treatment.
2. Expand internship programs, job shadowing and employment opportunities for middle and high school youth.
3. Provide assessment using the *Regional Resiliency Checkup* and intervention services, such as the Truancy Suppression Program or Community Service, at first school suspension or truancy arrest.

"Mistakes are a part of life. It is the response to error that counts." *Nikki Giovanni*

Ages 13–18 (Adolescence): JUVENILE PROBATION

What is the indicator?

The number of sustained petitions ("true finds") in Juvenile Court among youth ages 10-17.

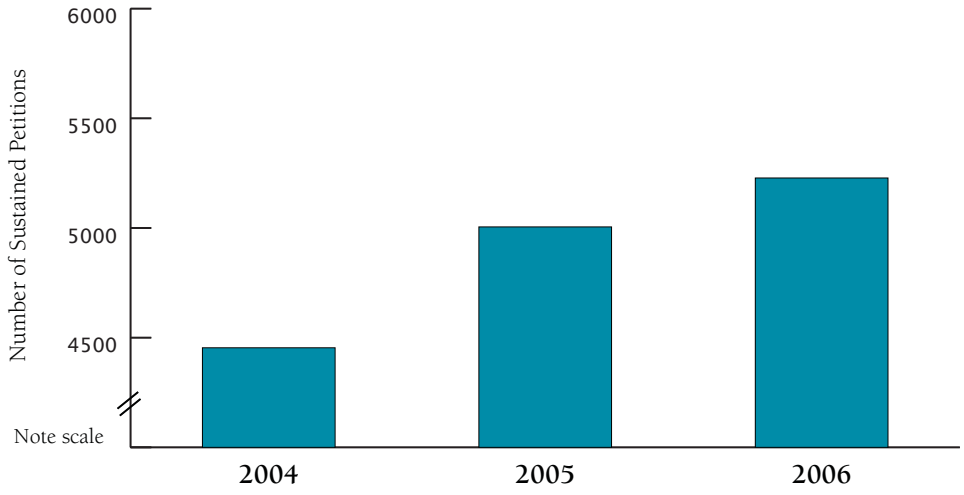
This indicator reports the number of sustained petitions (true finds) in the juvenile court system among youth ages 10-17. This is the juvenile equivalent of being found guilty in adult court. This indicator includes only sustained petitions for misdemeanor or felony offenses. Status offenses such as curfew or truancy violations are not included here. These data are collected by the San Diego County Probation Department.

Why is this important?

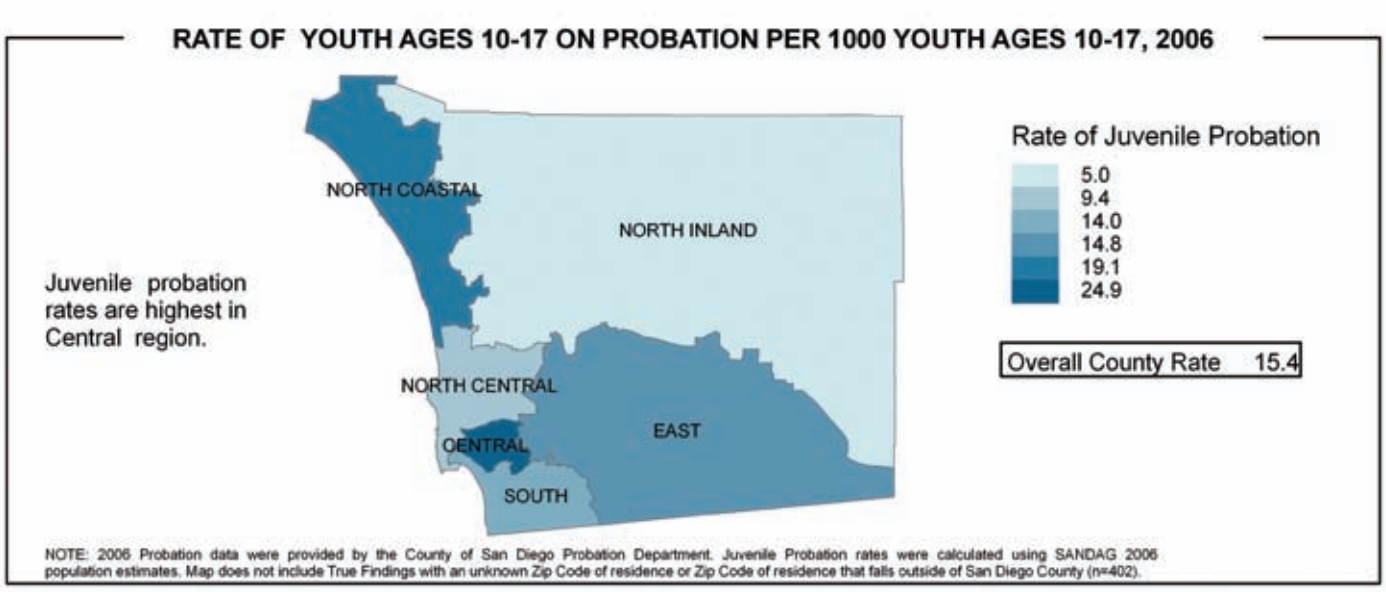
Breaking the law and engaging in risky and dangerous behaviors negatively impact a young person's life then and in the future. When a youth enters the juvenile justice system and has a sustained petition, they are likely to be placed on probation. While probation is an important tool, it is costly for the public and often represents failures to address early warning signs of risky behavior and problems among youth.

How are we doing?

Number of Sustained Petitions ("True Finds") in Juvenile Court, Youth Ages 10-17, San Diego County, 2004-2006



The number of sustained petitions has been steadily increasing in recent years, even while overall arrest rates have declined. This increase may be the result of multiple factors including: more previous offense history available during court proceedings, youth committing more felony crimes, more cases being referred to the court for immediate and swift consequences.



San Diego has developed and implemented many effective prevention and intervention programs, including Community Assessment Teams, Juvenile Diversion, Critical Hours, Breaking Cycles, and Multisystemic Therapy. These programs typically have a greater than 80% success rate in keeping kids out of or escalating in the juvenile justice system during the course of the program. The federal Office of Juvenile Justice Delinquency Prevention (OJJDP) highlighted San Diego County as one of the three most successful Comprehensive Strategy Pilots in the nation with regard to our "Best Practices" and Local Action Plan.

What strategies can make a difference?

Providing youth with clear, direct, and immediate consequences and support when they are engaging in risky behaviors and breaking the law provides youth with an understanding of appropriate boundaries, an opportunity to learn from their mistakes, and the ability to get back on track. Treatment, consistent and direct community supervision, and when needed, incarceration have been found to be effective in preventing increased delinquent behaviors, reducing recidivism, and improving public safety. Understanding the number and type of risky behaviors and laws broken can help communities develop strategies that keep young people from entering into or escalating within the justice system.

The following two categories of strategies have been used across the country to reduce future arrests and escalation in the justice system:

Incarceration Phase:

- Mental health evaluation and clinical supervision and substance abuse services.
- Basic educational services and literacy education.
- Vocational education and career development support.

Treatment and Community Supervision Phase:

- Community based drug treatment day/residential services.
- Wraparound support/service coordination, including job training and employment assistance.
- Assertive Community Treatment, Multisystemic Therapy (MST), Functional Family Therapy, and/or Aggression Replacement Training.
- Interventions to reduce gang recruitment and to help gang-involved youth exit a gang lifestyle.
- Victim/Offender Mediation, empathy training, and restitution.
- Parent training to develop communication skills and establish positive discipline patterns.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Probation Department, local law enforcement agencies, juvenile diversion programs, community based organizations, school districts, faith communities, Alcohol and Drug Services, substance abuse prevention agencies and mental health service providers to:

1. Evaluate community needs and gaps in services and expand successful relevant programs to match community needs, e.g., more drug and alcohol services in southeastern San Diego, more high school after school programs in North County.
2. Expand Juvenile Diversion services with law enforcement throughout San Diego County and with high school and middle school suspension and expulsion boards.
3. Expand intervention services such as Functional Family Therapy, Multi-Systemic Therapy, and mental health treatment programs to a broader population of at-risk youth.

"Drunk driving is the nation's most frequently committed violent crime."
Glynn Birch, MADD National President

Ages 13–18 (Adolescence): YOUTH DRIVING UNDER THE INFLUENCE (DUI)

What is the indicator?

The number of DUI arrests among youth under age 18.

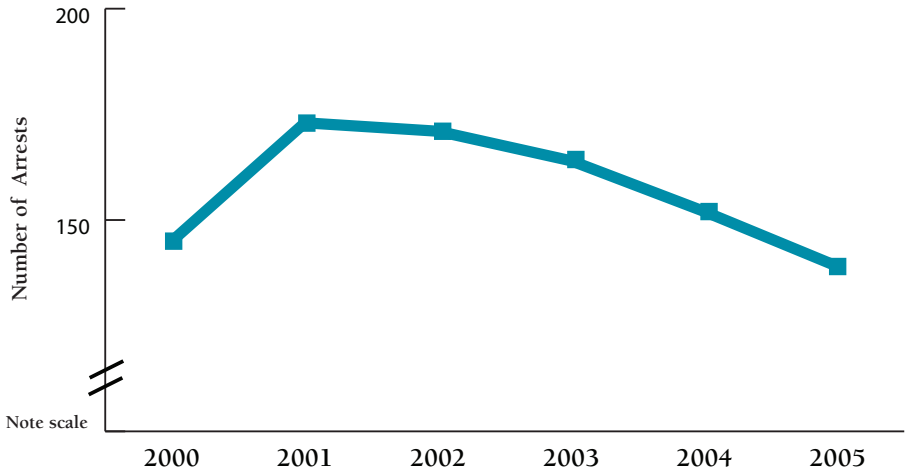
This indicator is the number of Driving Under the Influence (DUI) arrests among youth under age 18 as reported by the California Department of Motor Vehicles. It was selected as a gateway indicator for youth involved in alcohol- and drug-related collisions. Examining the statistics about our youth driving under the influence will help to identify opportunities for prevention and intervention, rather than looking only at the tragic end result of death and injury collisions.

Why is this important?

Driving under the influence is a serious hazard to health and safety. Less than 1% of drivers who self-report driving under the influence are caught and arrested for DUI. Over half of all children who die in motor vehicle crashes are riding with a drinking driver. Youth in the age group (16-20) for this indicator are not of legal age to drink, and research shows that early onset of drinking is associated with more frequent heavy drinking and likelihood of subsequent injury while drinking. Surveyed youth report that it is "no trouble" to obtain alcohol.

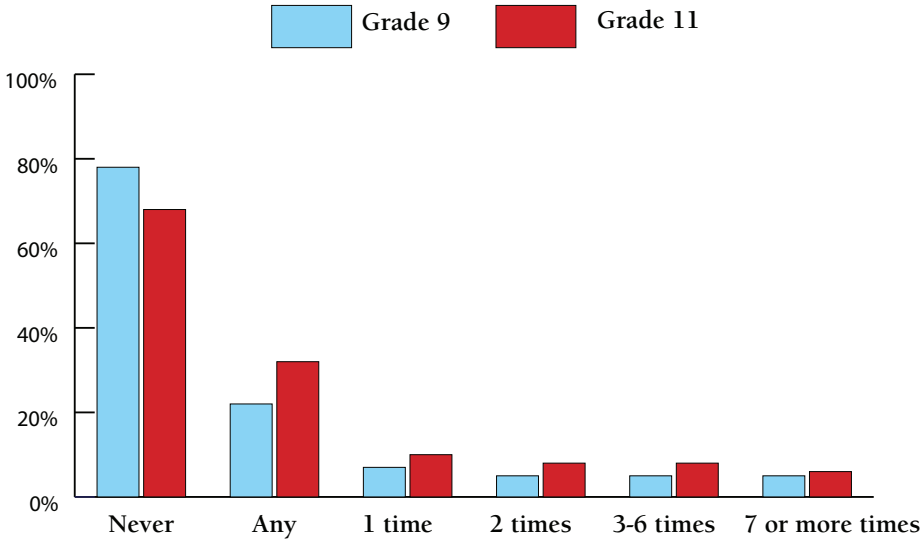
How are we doing?

Number of DUI Arrests, Youth under Age 18, San Diego County, 2000-2005



The trend is not improving overall in San Diego County. The number of youth DUI arrests spiked in 2001, and has been gradually dropping to reach approximately the same number as in 2000.

Percent of High School Students Driving or Riding with Friends Who Had Been Drinking, San Diego County, 2005



In 2005, 22% of 9th graders and 32% of 11th graders reported that within the last 30 days they had been in a car with a person who had been drinking. For some youth, this is a frequent occurrence even within a month's time.

What strategies can make a difference?

As with most issues, no single approach is sufficient to fix the problem. Driving under the influence is a behavior enforced by multiple influences, including social practices, perception of unlikely consequences, impaired judgment and decision making, denial, convenience, and identification with peer group.

The following strategies have been used across the country to reduce DUIs with young people:

- Aggressively enforcing existing 0.08% BAC laws, minimum legal drinking age laws, and zero tolerance laws for drivers younger than 21 years old in all states.
- Promptly suspending the driver's licenses of people who drive while intoxicated.
- Conducting sobriety checkpoints targeted at communities with highest incidences of alcohol- and drug-related accidents.
- Developing multi-faceted community-based approaches to prevent underage drinking.
- Reducing youth access to alcohol.
- Changing social norms regarding the use of alcohol and drugs.
- Empowering youth and building resistance and problem-solving skills through youth development opportunities.
- Educating parents about the risks and liabilities of "supervised" drinking.

How can we improve the trend in San Diego County?

San Diego and California have already implemented several best practices in preventing youth DUI, such as graduated drivers licenses, increased DUI penalties, a high conviction rate for DUI, school-based education programs, and sobriety checkpoints on holidays.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with school districts, parents, parent associations, the San Diego County Office of Education, local law enforcement agencies, Alcohol and Drug Services and substance abuse prevention agencies to:

1. Encourage youth involvement in local programs such as *Friday Night Live, Club Live*, sports and recreation programs, after school programs, and so forth.
2. Provide education to parents about the dangers of "social host" parties for youth and enact a liability law that imposes civil penalties and harsh fines on adults who provide alcohol to youth.
3. Enforce existing ordinances banning the sale of alcohol to minors and notifying parents after their child is cited for his or her first alcohol-related infraction.

"The fact is, drunk-driving crashes are 100 percent preventable."

South Dakota Attorney General Larry Long

Ages 13–18 (Adolescence):

MOTOR VEHICLE CRASHES INVOLVING YOUTH DUI

What is the indicator?

The rate of fatal and non-fatal crashes involving drivers ages 16-20 under the influence of alcohol or drugs per 100,000 population.

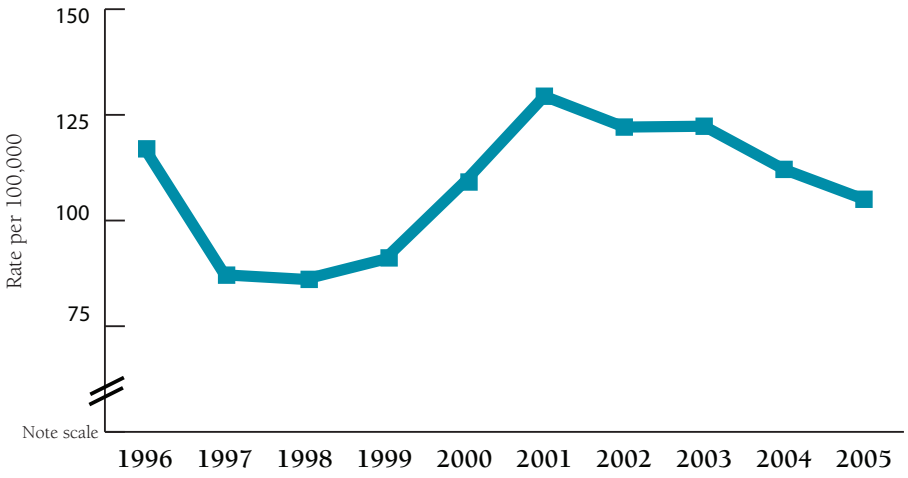
This indicator — the rate of fatal and non-fatal crashes involving drivers ages 16-20 under the influence of alcohol or drugs per 100,000 population — shows the extent to which our youth are drinking, driving, and crashing resulting in injury and death. Alcohol and drug involved means that at least one of the drivers involved in the crash had been drinking and/or using drugs.

Why is this important?

Teenagers in the U.S. have higher motor vehicle crash rates than adults, and the results are serious. Motor vehicle crashes are the leading cause of death for 15 to 20 year olds in the United States, accounting for about 40% of all teen deaths. Driving under the influence of alcohol and drugs is an important factor. Young men 18-20 report driving under the influence more than any other age or gender group. They are nearly twice as likely to have accidents, and to die in these accidents. Teens are more likely to have passengers in their cars when they crash, presenting a danger both to themselves and others. The true tragedy of these crashes is that they are highly preventable.

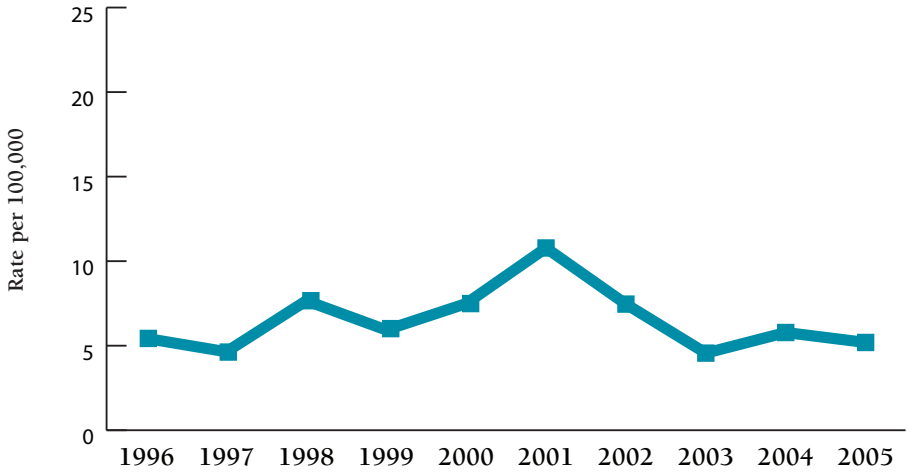
How are we doing?

Rate of Non-Fatal Crashes involving Drivers Ages 16-20 Under the Influence of Alcohol or Drugs, Per 100,000 Population, San Diego County, 1996-2005

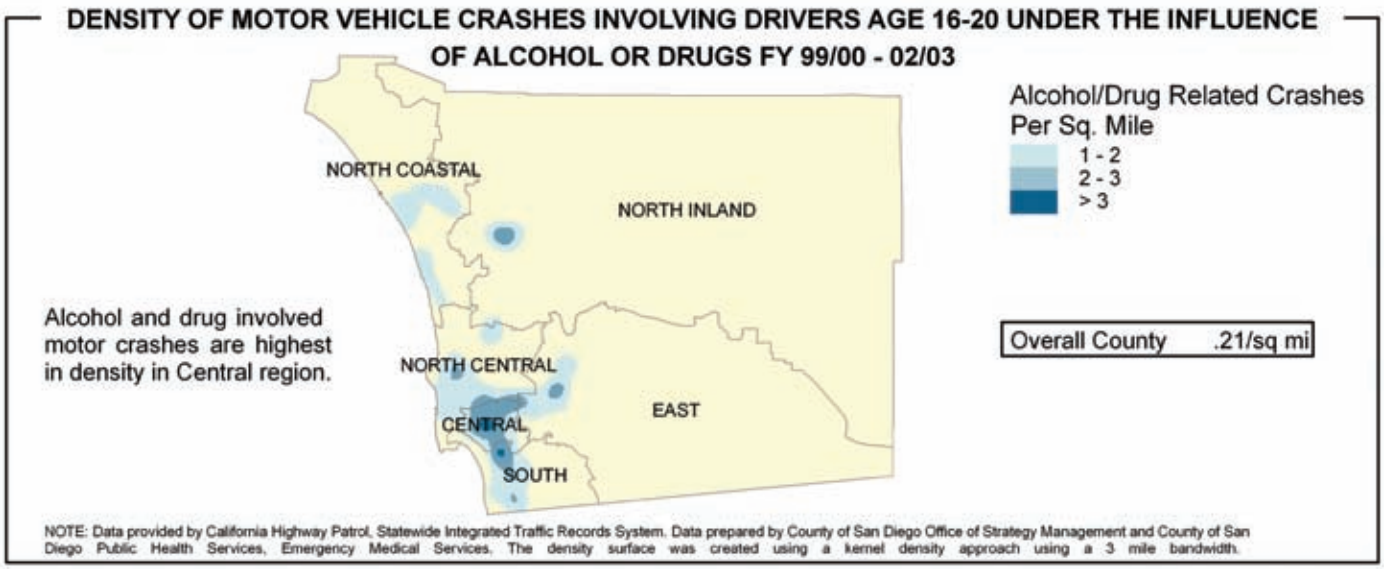


The trend is not improving overall. While non-fatal crash rates varied over time, San Diego County rates are basically at the same level as 10 years ago. San Diego is worse than the state rate and as with the state, the local number of drug-involved crashes is on the rise.

Rate of Fatal Crashes involving Drivers Ages 16-20 Under the Influence of Alcohol or Drugs, Per 100,000 Population, San Diego County, 1996-2005



The trend is not improving overall. The rate of fatal crashes spiked in 2001, and has been gradually dropping to reach approximately the same number as in 1999.



In 2005, San Diego County had the second highest number of these collisions in the state, second only to Los Angeles. A Children's Initiative study on the residence of youth involved in these crashes discovered that a few areas have higher rates. The five areas with the highest rates are Ramona, coastal San Diego, Fallbrook, La Mesa, and Escondido.

What strategies can make a difference?

Helping youth make the right decisions about both drinking and driving is critical but difficult, as concerned parents/citizens are not typically present when these decisions are made. Therefore, we need to prepare our youth ahead of time to make a safe decision. Current strategies use education, legal restrictions and consequences, and relational support to combat youth drinking and driving.

The following strategies have been used to reduce DUIs and related crashes:

- Providing quality driver education and training lasting at least three months.
- Implementing graduated driver licensing that includes a mandatory waiting period, nighttime driving restriction, at least 30 hours of supervised driving, and passenger restriction.
- Parents limiting their child's driving privileges during the first 12 months with a new license, the most dangerous period. Crash rates are the highest for the first 6 months and 1,000 miles of driving, regardless of other factors.
- Instituting community and school-based programs to maintain student and parent awareness about the dangers of drinking and driving.
- Targeting sobriety checkpoints in communities with highest incidences of alcohol- and drug-related accidents.
- Implementing mandatory seat belt laws.
- Maintaining a legal drinking age of 21.

How can we improve the trend in San Diego County?

San Diego and California have already implemented several best practices in preventing youth DUI, such as graduated drivers licenses, increased DUI penalties, a high conviction rate for DUI, school-based education programs, and sobriety checkpoints on holidays.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with local law enforcement agencies, school districts, parents, parent associations, driver education providers, businesses and business associations, automobile insurance companies and substance abuse prevention agencies to:

1. Increase sobriety checkpoints in communities with the highest incidences of youth alcohol- and drug-related motor vehicle crashes.
2. Focus on effective and affordable driver training, by requiring that behind-the-wheel training be provided by an accredited driver's training provider and reinstating driver's education training courses in schools.
3. Enforce existing ordinances banning the sale of alcohol to minors and notifying parents after their child is cited for his or her first alcohol-related infraction.

"If a free society cannot help the many who are poor, it cannot save the few who are rich."
President John F. Kennedy

Community and Family (Cross Age): POVERTY

What is the indicator?

The percent of children age 0-17 living in poverty.

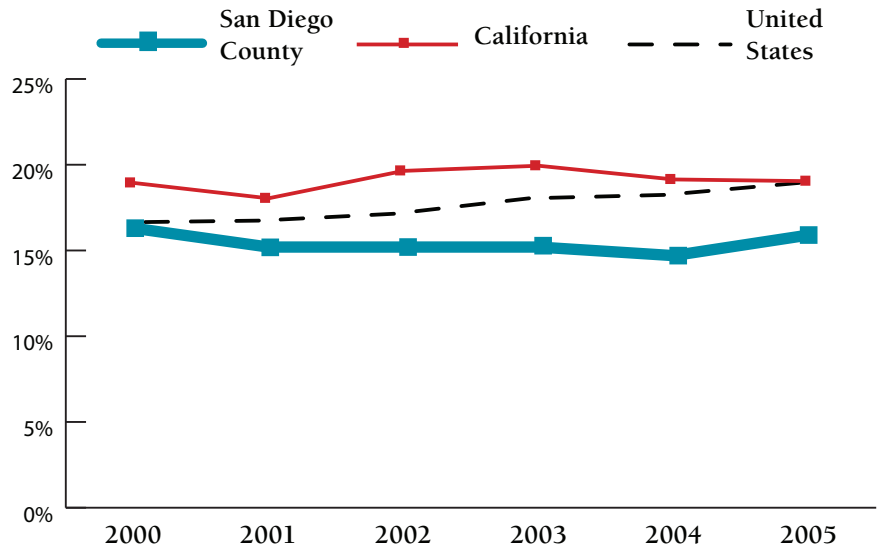
The indicator is the percent of children under age 18 living at or below 100% of the Federal Poverty Level. The Federal Poverty Level was set at an annual income of $20,000 for a family of four in 2006. In San Diego and California, the level of income sufficient to meet basic expenses such as housing and food (true cost of living) is closer to 200% of poverty. These data are routinely reported by the U.S. Bureau of the Census and by SANDAG.

Why is this important?

Living in poverty puts children at increased risk for a range of problems. The "dose" of poverty matters, that is, the more severe the poverty or more years a child lives in poverty, the worse the outcomes. Poor children are disproportionately exposed to risk factors that may impair brain development and affect social and emotional development. Exposures may be to environmental toxins, inadequate nutrition, maternal depression, parental substance abuse, trauma, abuse, violence, and low quality child care. Adolescents in poor families are more likely to engage in risky behaviors, including smoking, early initiation of sexual activity, drug and alcohol abuse, and delinquent behaviors.

How are we doing?

Percent of Children Ages 0-17 Living in Poverty, San Diego County, California, and United States, 2000-2005



The trend is maintaining. The percent of San Diego County children living in poverty is lower than the state and the national averages.

What strategies can make a difference?

Many factors play into the pernicious hold of the poverty cycle in families and communities. Government supports for low-income working families — such as Earned Income Tax Credits, child care subsidies, health insurance, food stamps, and housing assistance — can help break the cycle. These benefits encourage, support, and reward work by helping families close the gap between low wages and basic expenses. Other effective practices address family, cultural, neighborhood, educational, and job skill components. More than a decade of research shows that increasing the incomes of low-income families — without any other changes — can positively affect children's health and development, especially for younger children.

The following strategies have been used across the country to impact poverty:

- Focusing "welfare to work" programs on barriers to employment such as low education, poor work histories, substance abuse, and domestic violence so that these issues are recognized and addressed.
- Encouraging families to use federal and state Earned Income Tax Credits, a refundable tax credit for low-income individuals and families using federal income tax returns. According to the U.S. Government Accountability Office (GAO), 15 percent to 25 percent of qualified working families do not file to get their refunds/credits.
- Increasing parents' access to literacy, post-secondary, and vocational education.
- Providing free and low-cost job training and GED courses for working, single parents.
- Providing child care at education and training sites.
- Increasing level of education and reducing dropouts.
- Creating an Individual Development Account (IDA) program (e.g., Connecticut) to assist families in accumulation of assets through matched savings accounts.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with San Diego Workforce Partnership, work-development one-stops, community development corporations, community based organizations, faith communities, Behavioral Health Services, mental health service providers, Alcohol and Drug Services and substance abuse prevention agencies to:

1. Remove barriers to making a successful transition from welfare to work by providing supports such as mental health services, substance abuse services, and literacy services.
2. Expand services such as financial planning, education, job placement, and skill training to poor and low-income families.
3. Provide education and assistance in helping families apply for Earned Income Tax Credits through the San Diego Workforce Partnership network of providers.

"He who has health has hope; and he who has hope has everything." *Arabian proverb*

Community and Family (Cross Age): HEALTH COVERAGE

What is the indicator?

The percent of children age 0-17 who are without health coverage.

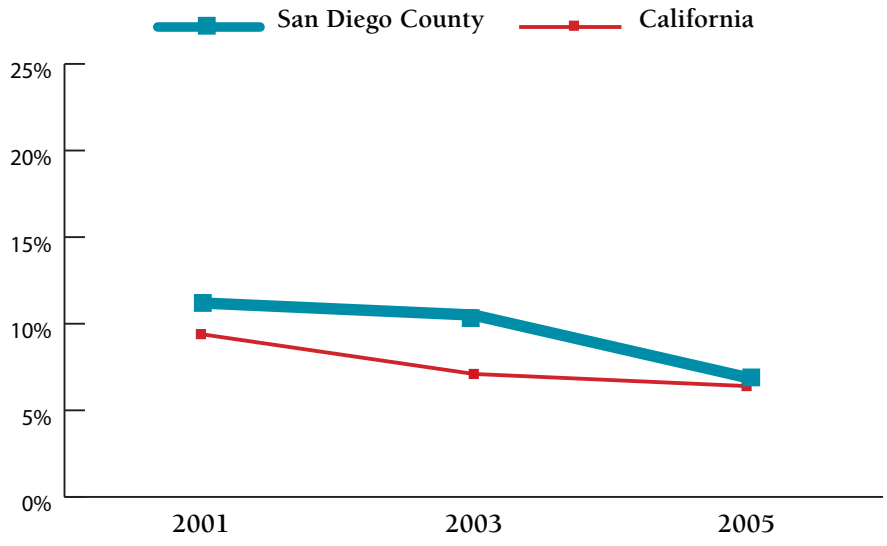
This indicator monitors the percent of children who are without health coverage in San Diego County. This information is routinely collected and reported through the California Health Interview Survey.

Why is this important?

The single greatest barrier to receiving medical care is lack of health coverage. Uninsured children are less likely than their insured counterparts to receive preventive services and needed interventions for problems. For children with special health care needs (those with chronic conditions that typically require extra care and treatment), lack of coverage can mean more hospitalizations for untreated asthma, poorly treated vision or hearing problems, and worsening disabilities. Thirty years of research has shown that children with publicly subsidized health coverage (e.g., Medi-Cal) use services in approximately the same amounts and patterns as those who have private insurance.

How are we doing?

Percent of Children Ages 0-17 without Health Coverage, San Diego County and California, 2001, 2003, and 2005



The trend is improving. By 2005, 7% of San Diego's families reported that their children were without health coverage. San Diego County was on par with the state average, and well above the national level of 17% of children without coverage.

What strategies can make a difference?

With expansions of Medicaid and the State Children's Health Insurance Program (S-CHIP, known as Healthy Families in California), most children with a family income below 200% of the federal poverty level are eligible for publicly subsidized coverage when no employer-based coverage is available to them. Additionally, the initiation of the Kaiser Child Health Plan for children with family income up to 300% of the federal poverty level has helped to decrease the number of uninsured children. Assuring that families know that such coverage is available and simplifying eligibility is essential.

The following strategies have been used across the country to increase health coverage for children:

- Developing effective outreach and enrollment strategies such as those used in the "Covering Kids" projects at the state- and community-level across the country, including:
  1. Campaigns to promote awareness of available coverage (e.g., culturally specific marketing tools, outreach through McDonalds, billboards and posters)
  2. Assistance in distributing and completing applications in schools and the workplace
  3. Incentives for schools, employers, and community-based organizations to identify families and help them enroll their children
- Simplifying and streamlining the application process and enrollment policies (e.g., shortening forms, accepting applications by mail or Internet, eliminating asset tests, eliminating the need for initial fee with the Healthy Families application)

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with self-sufficiency programs, family resource centers, parents, faith communities, California Department of Health Services, Health and Human Services Agency, community clinics, community based organizations, schools and school districts to:

1. Expand outreach, enrollment, and retention efforts for communities with high concentrations of low-income children, using presumptive eligibility, cross-system linkage, and the Child Health Disability and Prevention Program (CHDP) gateway follow-up.
2. Expand use of federally required outreach and eligibility workers at locations such as community clinics and WIC offices, as well as Certified Application Assistors (CAA).
3. Continue and expand county/schools partnership in active outreach and in supporting families in the application and retention process for Medi-Cal and Healthy Families.

"Domestic violence causes far more pain than the visible marks of bruises and scars."
Senator Dianne Feinstein

Community and Family (Cross Age): DOMESTIC VIOLENCE

What is the indicator?

The rate of domestic violence reports per 1,000 households.

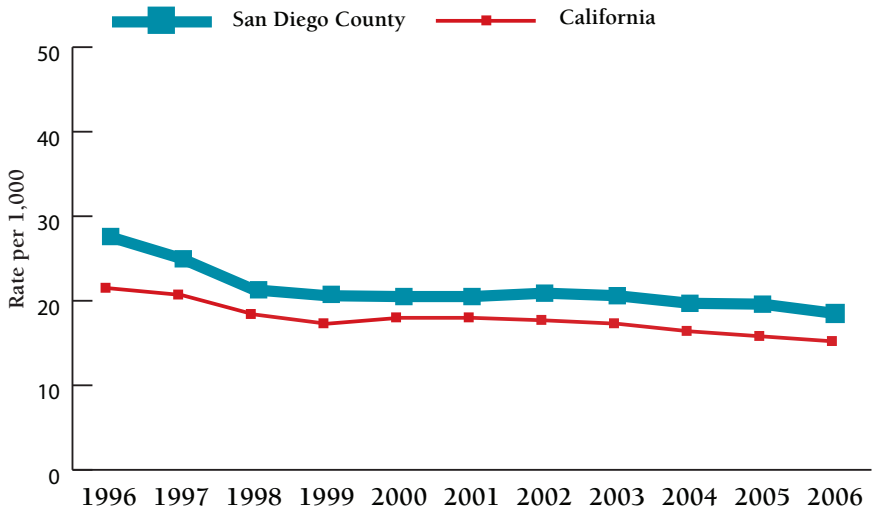
This indicator — the rate of domestic violence reports per 1,000 households — documents the rate of reports of domestic violence and intimate partner violence made to San Diego County law enforcement agencies. The rate of police reports is generally closer to the actual rate at which violence is occurring than is the number of arrests or convictions made. The number of reports is considered to be an under-estimate, as many incidents go unreported. These data are collected and reported by ARJIS.

Why is this important?

Domestic violence affects everyone involved, either directly or through exposure to violence. The abused partner may suffer both physical and mental trauma, which may manifest as fear, anxiety, depression, and post-traumatic stress. Exposed children live in fear and hopelessness, often perform poorly in school, and may be unable to participate in normal childhood activities. It typically escalates over time, moving from verbal abuse to emotionally abusive behavior, to physical abuse, and can result in death. Children from violent households often have increased aggression, increased risk of victimization, problems forming healthy relationships, lowered social competence, and poorer academic performance.

How are we doing?

Rate of Domestic Violence Reports, Per 1,000 Households, San Diego County, 1996-2006



The trend is improving. The rate of domestic violence reports is declining in San Diego County. The County rate has consistently been worse than the state average, however.

What strategies can make a difference?

The following strategies have been used across the country to reduce the incidence of domestic violence:

- Routinely screening for abuse in health care settings.
- Ensuring cross-system reporting of child abuse and domestic violence to increase consistency, for example, in filing Suspicious Injury and Suspected Child Abuse reports.
- Regular review of domestic violence incidents to evaluate gaps in the service system.
- Ongoing education for judges on domestic violence to ensure consistency in sentencing.
- Ensuring enforcement of perpetrators' mandated treatment, including attendance at year-long violence prevention programs and other terms of probation.
- Ensuring the removal/submission of firearms in households where domestic violence occurs.
- Creating "No wrong door" policies and centers for victims.
- Increasing school programs to raise awareness about healthy relationships and the risk of teen dating violence and provide resources to support youth.
- Helping victims develop and continually update their safety plans.
- Providing Trauma-Focused Therapy and Parent-Child Interaction Therapy.
- Developing well-trained advocates available to assist victims and their families.

How can we improve the trend in San Diego County?

San Diego has been working across systems and agencies to implement a countywide system of care for children and families exposed to domestic violence. Efforts include development of region specific plans and a cross-system team working with children in the child welfare system who have been exposed to domestic violence. The City of San Diego opened a comprehensive "one-stop" center to assist victims and is building a second center. In 2007, countywide law enforcement protocols were updated to reflect changes in law regarding responses to children exposed to domestic violence. San Diego also revised and standardized a countywide DV Supplemental form for law enforcement reporting. This form will now document the number of children living with either the suspect or victim of domestic violence.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Office of Violence Prevention, Public Health, school districts, faith communities, Behavioral Health Services, mental health service providers, Alcohol and Drug Services, substance abuse prevention agencies, American Academy of Pediatrics and educators to:

1. Increase cross-system training in identification, screening, and assessment of domestic violence (e.g., Public Health nurses, teachers, mental health providers, alcohol and drug counselors).
2. Increase the use of routine developmental screening in early childhood (with objective tools) to increase the identification of young children exposed to violence and other trauma.
3. Increase the capacity to provide therapeutic interventions for domestic violence.

RATE OF DOMESTIC VIOLENCE INCIDENTS PER 1000 HOUSEHOLDS, 2006

The rate of domestic violence incidents is highest in Central region.

Rate of Domestic Violence

12.4
13
17.8
20.1
24.4
27.2

Overall County Rate	18.5
California State Rate	14.3

NOTE: Data provided by Automated Regional Justice Information System, ARJIS. Data prepared by County of San Diego Health and Human Services Agency with assistance from the District Attorney's Office. Rates were determined based on SANDAG 2006 Household Estimates.

"You didn't have a choice about the parents you inherited, but you do have a choice about the kind of parent you will be." Marion Wright Edelman, Children's Defense Fund

Community and Family (Cross Age): CHILD ABUSE AND NEGLECT

What is the indicator?

The rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17.

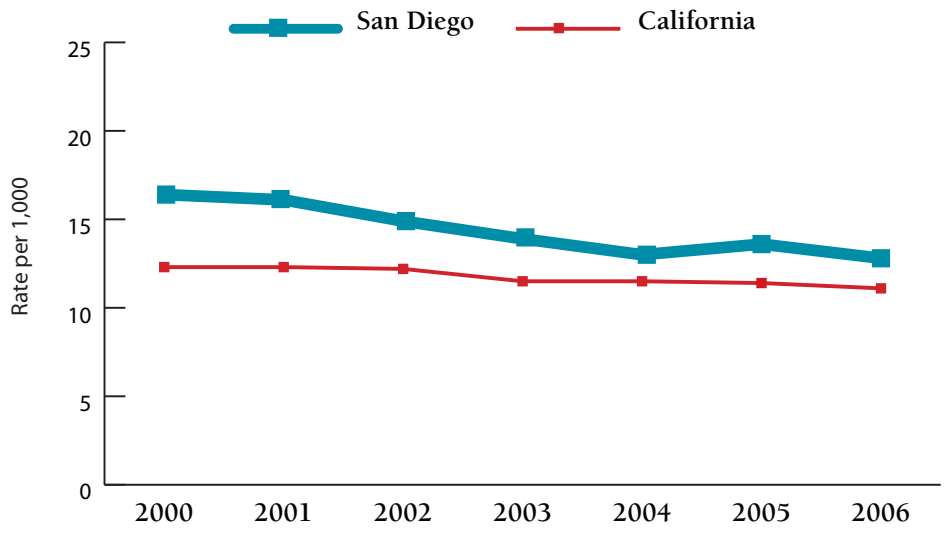
This indicator — the rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17 — shows trends in reports of child abuse and neglect that are found through investigation to have sufficient evidence to warrant a child welfare services case being opened or having the family referred for services. These data come from reports filed by our county's Child Welfare Services to a state database managed by the University of California Berkeley.

Why is this important?

Child abuse and neglect has profound and often long-term effects on a child's health, well-being, mental and emotional health, and even cognitive development. Physical effects include injury and disability, even death; psychological effects include depression, anger, self-harm behaviors, anxiety, and aggression; and cognitive issues include impacts on brain development. Abused and neglected children often have social and behavioral problems, and research shows that they are less likely to succeed in school. Recent attention has also been drawn to shaken baby syndrome as these deaths appear to be increasing.

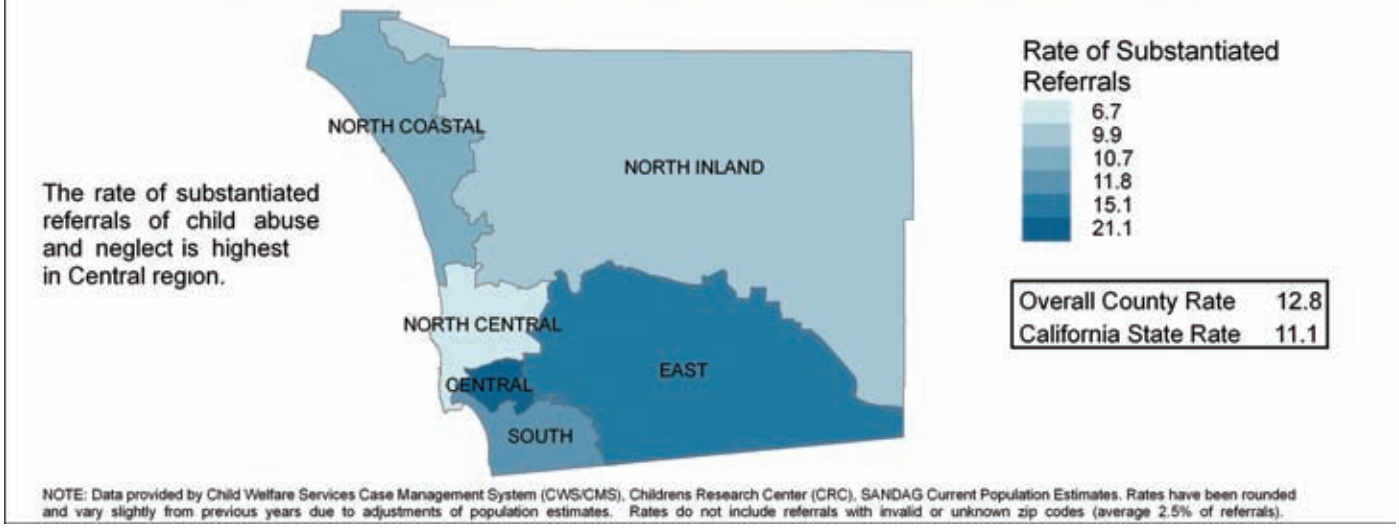
How are we doing?

Rate of Substantiated Cases of Child Abuse and Neglect Per 1,000 Children Ages 0-17, San Diego County and California, 2000-2006



The San Diego County rate has been slowly declining since at least 2000, but at 12.8 per 1,000 the local rate remains higher than the state average.

RATE OF SUBSTANTIATED REFERRALS OF CHILD ABUSE & NEGLECT, 2006



NOTE: Data provided by Child Welfare Services Case Management System (CWS/CMS), Childrens Research Center (CRC), SANDAG Current Population Estimates. Rates have been rounded and vary slightly from previous years due to adjustments of population estimates. Rates do not include referrals with invalid or unknown zip codes (average 2.5% of referrals).

What strategies can make a difference?

Child abuse is associated with many factors, including parental substance abuse, unemployment, poverty, history of abuse, domestic violence, anger, isolation from the community, mental health problems, stress, sociopathy, and cultural beliefs. Effective intervention should be tailored to the factors contributing to the individual situation.

The following strategies have been used across the country to reduce the incidences of child abuse and neglect:

- Developing parent support groups and parenting classes teaching age-appropriate communication, expectations, and intervention, beginning in early childhood.
- Increasing social supports for at-risk families, including home visitor programs and in-home intervention and training.
- Providing respite care for high-stress and emergency situations.
- Offering family training to improve parent-child relationship skills for families at risk and with identified problems.
- Training health providers, teachers, and other care providers to recognize signs of abuse and neglect, as well as information regarding community resources available.
- Providing sustance abuse and mental health services with incentives to participate in and complete programs.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with Child Welfare Services, parents and parent associations, local businesses and business associations, Behavioral Health Services, mental health service providers, community based organizations, faith communities, California Department of Health Services, United Way of San Diego County, and the Probation Department to:

1. Expand participation in parent support groups and parenting classes through incentives such as child care, store certificates, and meal provision.
2. Expand and sustain effective in-home support and intervention programs such as Child Safe, Therapeutic Behavioral Services, Community Assessment Teams, and Families Forward.
3. Expand home visiting and similar programs to intervene and build parent skills and supports in early childhood.

"You ask yourself — as parent, sibling or concerned community member — whether you are doing all you can to keep children safe." *Polly Klaas Foundation*

Community and Family (Cross Age):

VIOLENT CRIME VICTIMIZATION OF CHILDREN

What is the indicator?

The rate of violent crime victimization per 10,000 children or youth ages 0-11 and 12-18.

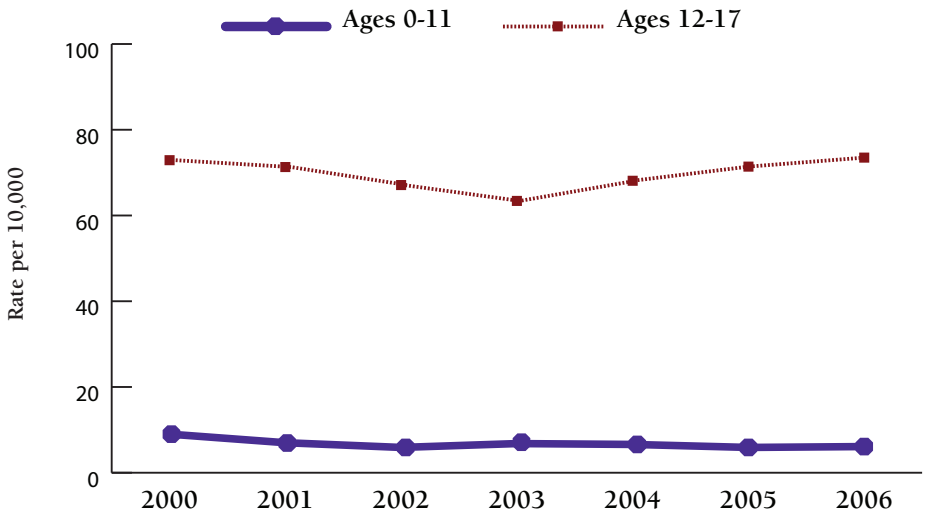
This indicator — the rate of violent crime victimization of children — reflects trends in four types of crime (homicide, rape/sexual assault, aggravated assault, robbery by force or threat). The data are from the Automated Regional Justice Information System (ARJIS), so only those incidents that result in an arrest report are represented. In future Report Cards, data from the Emergency Medical Services and pre-hospital reports may be available to monitor incidents that do not result in an arrest.

Why is this important?

Violent crimes perpetrated against children are disturbing breaches in the health and safety net that communities build for children and youth. Nationally, children and adolescents are one of the groups most likely to be victims of crime overall, and are also victims of crimes specific to childhood, such as sexual abuse and family abduction. In fact, according to the National Crime Victimization Survey, teenagers are two to three times more likely than adults to be the victims of assault, robbery, or rape. Nearly half of all rapes are committed against girls under 18. Victimized children are at high risk for post-trauma impacts such as emotional, behavioral, and academic problems.

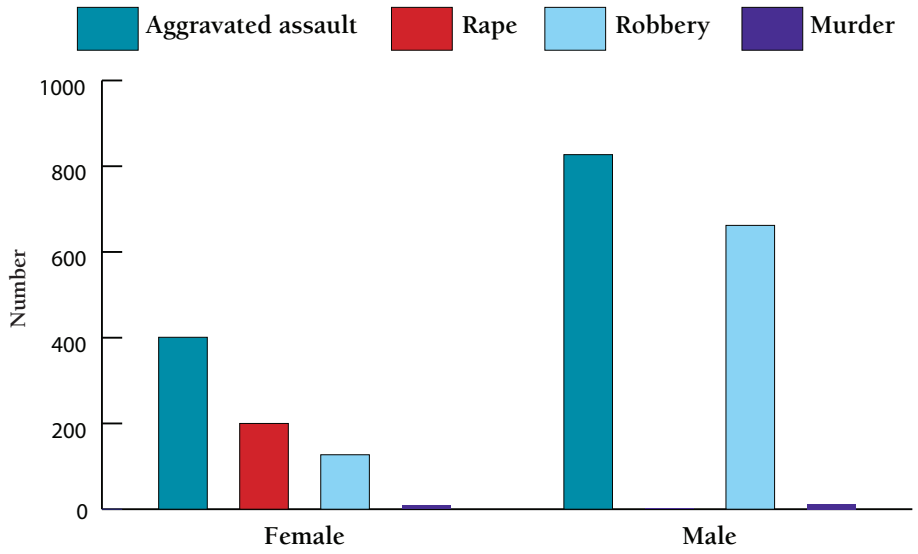
How are we doing?

Rate of Violent Crime Victimization Per 10,000 Children, Ages 0-11 and 12-18, San Diego County, 2000-2006



The overall trend is maintaining. The rate of violent crime victimization of younger children did not change substantially. Of concern is that after declining steadily from 2000-2003, the rate of victimization for youth ages 12-17 has returned to the highest rate since 1999. San Diego has a higher rate than California.

Number of Children Ages 0-18 Who Were Victims of Violent Crime, By Type of Crime and Gender of Victim, San Diego County, 2006



The largest share of these crimes against children were aggravated assaults. The pattern is different for girls. Girls experienced half the number of crimes that boys did, and more than a quarter of these were rape/sexual assault. The majority of the crimes experienced by boys were aggravated assault and 4 in 10 incidents were robberies

What strategies can make a difference?

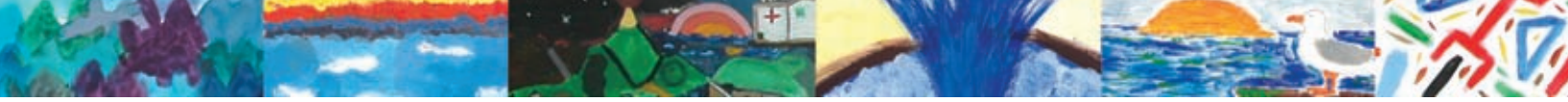
The following strategies have been used across the country to reduce violent crime victimization of children and youth:

- Developing school-wide behavior policies and codes of conduct.
- Developing school anti-violence and anti-bullying policies, prevention programs and intervention programs such as OLWEUS Bullying Prevention, PeaceBuilders, Providing Alternative Thinking Strategies (PATHS), and the Resolving Conflict Creatively Program (RCCP).
- Educating parents, caregivers, and youth serving organizations about Internet safety programs including monitoring and restriction of use and Internet controls.
- Implementing conflict resolution programs in schools, after school programs, and in youth serving community organizations.
- Implementing gender specific services for girls.
- Implementing gang prevention and intervention programs.
- Training parents, school personnel, after school staff, youth serving organizations, and community clinics in the identification and prevention of bullying, intimidation, and sexual harassment.
- Assuring "safe passages" for children and youth to and from school.
- Increasing youth (especially girls) and parent knowledge of and ability to protect against sexual assault and rape.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with school districts, San Diego County Office of Education, community based organizations, Office of the Attorney General, California Department of Education, Office of Violence Prevention, parents and parent associations, faith communities, community centers and neighborhood associations to:

1. Expand violence prevention and bullying prevention programs at schools, after school programs, youth serving community centers, and in community based organizations.
2. Expand the *Safe Passage* program to communities with highest incidences of youth aggravated assaults.
3. Increase education and programs for girls which promote youth development, physical safety, and assertiveness.



"If a disease were killing our children in the proportion accidents are, people would be outraged and demand this killer be stopped." *C. Everett Koop, Former U.S. Surgeon General*

Community and Family (Cross Age): UNINTENTIONAL INJURY HOSPITALIZATIONS AND DEATHS

What is the indicator?

The rate of unintentional injuries per 100,000 children ages 0-18.

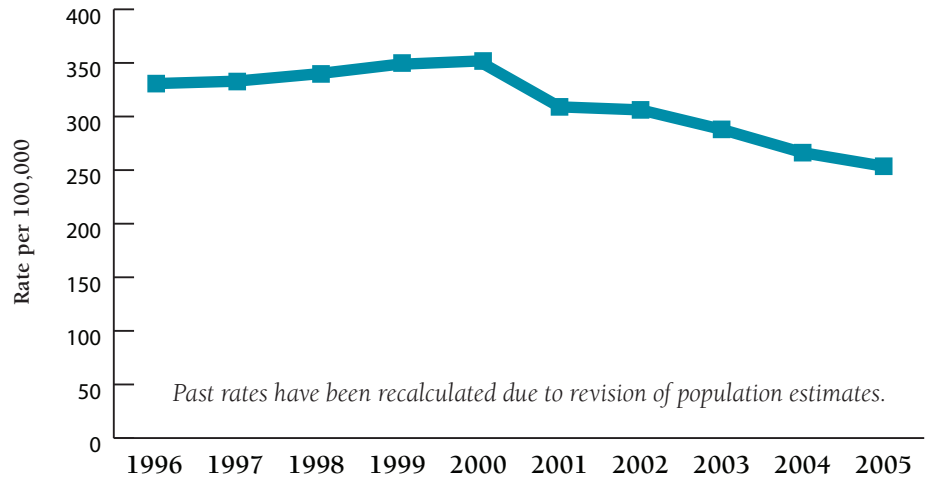
This indicator — the rate of hospitalized and fatal unintentional injuries per 100,000 children 0-18 — shows trends in how many children are injured sufficiently to require hospitalization or who die of accidental causes. These data are routinely reported on hospital discharge reports and death certificates.

Why is this important?

As a group, unintentional injuries are the leading cause of death for children. These injuries cost society millions in lost productivity and associated medical expenses. The true tragedy of these injuries and deaths is that they are largely preventable. Significant reductions in injuries been achieved through legislation and education that resulted in increased use of seat belts, bike helmets, hot water heater limits, gun safety, and pool fencing.

How are we doing?

Rate of Fatal and Non-fatal Unintentional Injuries per 100,000 Children Ages 0-18, San Diego County, 1996-2005



The trend is improving. The rate of non-fatal unintentional injuries to children has been decreasing gradually over the last 10 years. San Diego County's childhood injury rates have been slightly below the state average. Both the San Diego County (27.7) and the California rates (29.3) of unintentional injury deaths are higher than the national objective (17.5), leaving room for improvement.

What strategies can make a difference?

While unintentional injuries are the leading cause of death it is important that each cause of unintentional injury and death be addressed individually. Each cause must be evaluated and specific prevention and intervention strategies must be developed. Legal mandates and public education about safety are the primary tools for reducing injuries.

The following two categories of strategies have been used across the country to reduce unintentional injuries:

Provding education about:

- Firearm safety.
- Protective wear such as bicycle helmets.
- Protective restraints such as child car seats and seat belts.
- Common causes of choking and suffocation.
- Home safety precautions such as outlet covers, cabinet locks, stair safety gates, and hot water heater control.
- Fire prevention and reaction, including fire skills training.
- Safe driving practices for parents and youth.
- Parental supervision and child-proofing environments.

Enacting and enforcing legislation and regulations to require:

- Smoke detectors, hot water heater controls, and stair safety gates in rental properties.
- Protective restraints such as child safety car seats and car seat belt use.
- Pool fencing and self-closing gates.
- Graduated licensing for teens.
- Toy manufacturer safety standards.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with San Diego Safe Kids Coalition, parents and parent associations, local law enforcement, landlord associations and municipalities to:

1. Increase education to parents and caregivers regarding the importance of the correct use of child safety seats and booster seats.
2. Increase enforcement of existing child vehicle restraint laws and helmet laws requiring that children and adolescents under 18 wear a helmet while riding a bicycle, skateboard, scooter, rollerblades, or "Heelys."
3. Develop and/or increase enforcement of safety regulations in rental properties (e.g., safety gates, regulating hot water temperature, window safety devices, fences around pools and play areas), existing occupant protection laws (for rental properties), and stronger penalties for violations.

"Untimely death is a great evil. What is so bitter as the premature death of a wife, a child, a father..." *Charles Dickens*

Community and Family (Cross Age): CHILDHOOD MORTALITY

What is the indicator?

The mortality rate per 1,000 children ages 0-17.

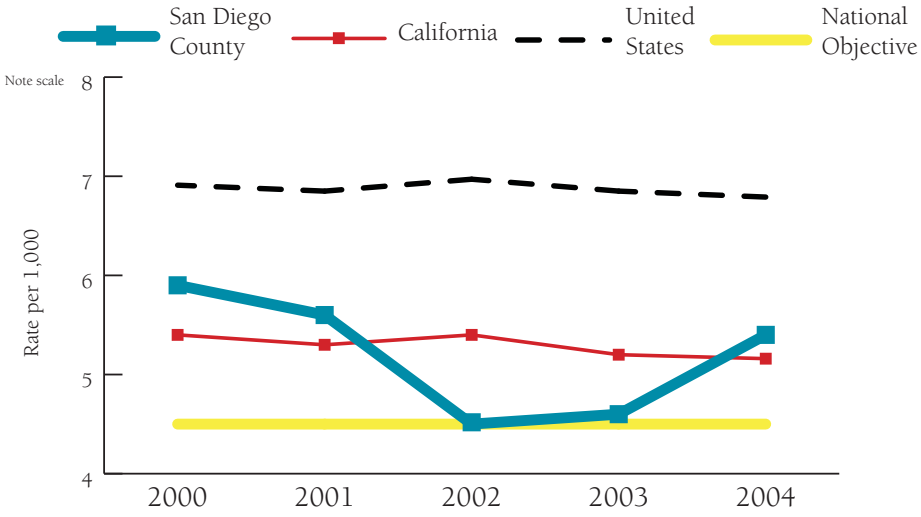
This indicator -the rate of mortality for children ages 0-17 monitors the rate at which infants, children and youth die. These data are recorded on death certificates and routinely reported as part of local, state, and federal vital statistics.

Why is this important?

Child mortality is one of the most basic indicators of a community or country's well-being. Child mortality is related to a variety of health factors (e.g., risk of disease, safety practices) and socioeconomic conditions (e.g., sanitation, housing). The leading causes of death vary by age. About two-thirds of infant deaths occur in the first month after birth and are primarily due to health conditions at the time of birth, such as low birthweight or birth defects. Older children are more likely to die of external causes such as motor vehicle accidents, drowning, burns, suicide, and homicide. Cancer, heart conditions, and pneumonia/influenza are also among the top ten causes of childhood mortality. Many deaths among children are preventable.

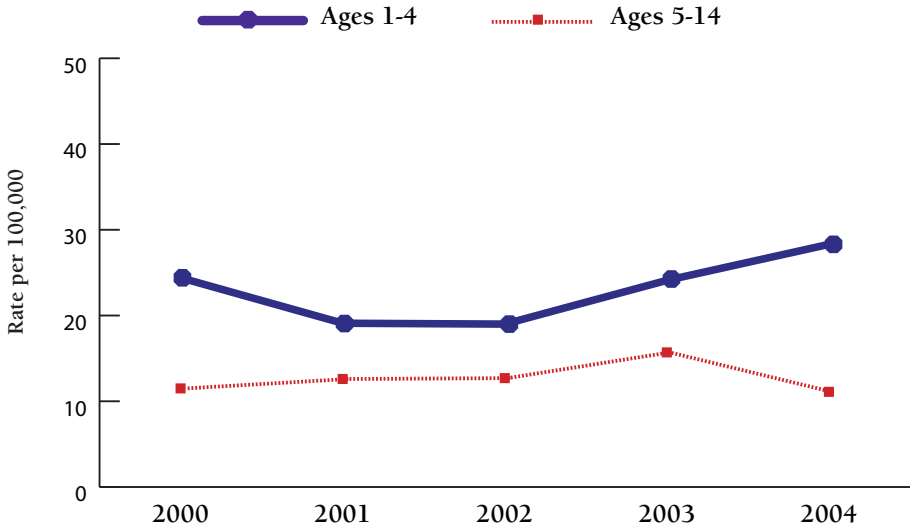
How are we doing?

Infant Mortality Rate Per 1,000 Children Ages 0-1, San Diego County, California, and United States Compared to National Objective, 2000-2004



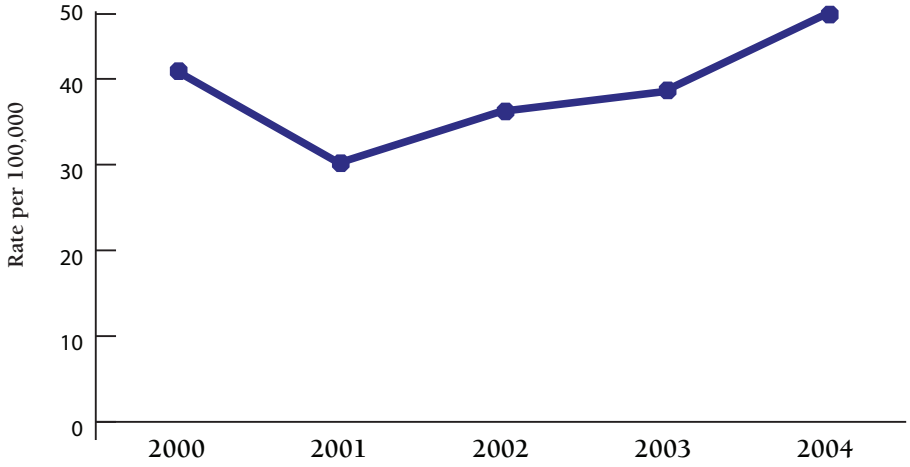
The trend is maintaining, with some fluctuations. San Diego County's infant mortality rate is better than the state or national averages. For two years, we reached the national objective.

Rate of Mortality Per 100,000 Children Ages 1-4 and 5-14, San Diego County, 2000-2004



The trend is maintaining for children. The rates of mortality for children ages 1-4 decreased slightly from 2000-02 and increased slightly 2002-04. The trend was reversed for children ages 5-14, but did not change significantly.

Rate of Mortality Per 100,000 Children Ages 15-17, By Age, San Diego County, 2000-2004



The trend is moving in the wrong direction for youth ages 15-17. The mortality rate increased slightly from 2001 to 2004.

What strategies can make a difference?

Childhood mortality can be an indicator of risks and conditions such as disease, poor maternal health, adverse living conditions, environmental hazards, lack of access to health services, risky behavior, and other factors. It is important when working to reduce childhood mortality to design and implant specific strategies for each age group. Studies show that communities must develop strategies that are age appropriate and developmentally suitable.

The following strategies have been used across the country to reduce childhood mortality:

- Supporting Child Death Review Teams to identify risk factors and interventions that could prevent future deaths.
- Conducting community campaigns to reduce factors that place infants, children, and adolescents at risk for premature death.
- Educating parents before they leave the hospital with a newborn about sleeping position ("back to sleep") to prevent Sudden Infant Death Syndrome (SIDS), and about shaken baby syndrome.
- Providing car seats for infants, toddlers, and young children.
- Educating parents and children about the risks of drowning at home and across the community.
- Promoting gun safety (e.g., safe gun storage, "safe surrender" or "buy-back") programs.
- Promoting suicide awareness and prevention programs.
- Requiring driver safety education programs for new teen drivers.

How can we improve the trend in San Diego County?

San Diego was one of the first counties in the state to form a Child Death Review Team to study circumstances of deaths and identify opportunities for prevention and intervention. Review teams use case studies of children's deaths to identify prevention and intervention opportunities.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with San Diego Safe Kids Coalition, San Diego Child Death Review Team, First 5 San Diego, United Way of San Diego County, schools and school districts, parents and parent associations, community clinics, Public Health, faith communities, community based organizations, local law enforcement, American Academy of Pediatrics and Child Welfare Services to:

1. Implement the recommendations of the Child Death Review Team and take action to further prevent deaths.
2. Work with First 5 San Diego and the United Way to implement and expand campaigns regarding prevention of shaken baby syndrome and SIDS.
3. Continue and expand gun safety programs, which protect children at all ages from firearm-related accidental injuries and deaths, suicide, and homicide.

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School Attendance
Data provided for this *Report Card* by individual San Diego County school districts. The data represents 90% of county student population. This is the first year gathering this data. The Children's Initiative will be working closely with school districts in subsequent years to further standardize data collection and reporting.

School Achievement (Grade 3)
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Obesity
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Ages 13 to 18

School Attendance
Data provided for this *Report Card* by individual San Diego County school districts. The data represents 90% of county student population. This is the first year gathering this data. The Children's Initiative will be working closely with school districts in subsequent years to further standardize data collection and reporting.

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Health Coverage
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Domestic Violence
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Child Abuse and Neglect
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